

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04654

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04654

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Garrison		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
c. LENGTH OF STAY IN 1b 4 days		d. STREET ADDRESS 130 Slade Ave., Apt. 113	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Foxleigh Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Abraham Middle Abrams Last Abrams		4. DATE OF DEATH Month April Day 5 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 2, 1886
9. AGE (In years last birthday) 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Real Estate	11. BIRTHPLACE (State or foreign country) Russia
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Isser Abrams	
14. MOTHER'S MAIDEN NAME Leah ?		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No	
16. SOCIAL SECURITY NO. 214-01-2357		17. INFORMANT Address Balto., Md. Mrs. Rose Abrams, 130 Slade Ave., Apt. 113	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Arteriosclerotic Hypertensive C-V Disease (b) Uremia DUE TO Chr. Nephrosclerosis (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1142X			INTERVAL BETWEEN ONSET AND DEATH 2 wks. est. 10 yrs. 1 mo. est. 10 yrs. est.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured hip-pinned; Chr. Emphysema			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Slipped in bathtub & fractured hip(right)	
20c. TIME OF INJURY Month, Day, Year 7 AM 3-15 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home	20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 4-5-67		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-6-67	23c. NAME OF CEMETERY OR CREMATORY Beth Tfiloh
23d. LOCATION (City or Town) (County) (State) Baltimore Md.		24. FUNERAL DIRECTOR ADDRESS Sol Levinson & Bros. Inc., 6010 Reist. Rd.	
25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04655

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD, MARYLAND				c. LENGTH OF STAY in 1b 1 DAY			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. STREET ADDRESS 5724 ROCK SPRING ROAD			
3. NAME OF DECEASED (Type or print) First LEONARD Middle -- Last ADELHARDT				4. DATE OF DEATH Month APRIL Day 10 Year 19 67			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 24, 1893	9. AGE (In years last birthday) yrs. 73	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN ADELHARDT				14. MOTHER'S MAIDEN NAME LOUISE KEMPER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 10 99 90		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE INTRA ABDOMINAL HEMORRHAGE 199.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) HEMORRHAGIC SARCOMA INVOLVING LIVER, SPLEEN AND SMALL INTESTINE DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4/9/67 , 19__ to 4/10/67 , 19__, that (X) (we) last saw the deceased alive on 4/10/67 , 19__, and that death occurred at 1:15 P M, from causes and on the date stated above.							
22a. SIGNATURE John D. Talbert				22b. DATE SIGNED 4/10/67		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND				22e. REC'D BY REGISTRAR APR 13 1967		22f. REGISTRAR'S SIGNATURE Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/13/67		23c. NAME OF CEMETERY OR CREMATORY LOUDEN PARK CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR LORING BYERS FUNERAL CHAPEL		24b. ADDRESS RANDALISTOWN, MARYLAND		24c. REC'D BY REGISTRAR APR 13 1967		24d. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04656.

CERTIFICATE OF DEATH

04656

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE md. b. COUNTY P. G. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE			c. LENGTH OF STAY IN 1b ABOUT 18 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HILLSIDE md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 5603 LOT 2 E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BLANCHE Middle L. Last ALLISON				4. DATE OF DEATH Month APRIL Day 15 Year 1967			
5. SEX FEMALE		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-1-1878	
9. AGE (In years last birthday) yrs. 89		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) PENNA.	
12. CITIZEN OF WHAT COUNTRY? U.S.				13. FATHER'S NAME WASHINGTON HARMON			
14. MOTHER'S MAIDEN NAME SUSANNA DUSTIN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-03-4463				17. INFORMANT Address SPRING GROVE STATE HOSP CATONSVILLE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) PARKINSONISM (c) GENERALIZED ARTERIO SCLEROSIS							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11-11-1965 , to 4-15-1967 , that (I) (we) last saw the deceased alive on 4-15-1967 , and that death occurred at 7-15 AM , from causes and on the date stated above.							
22a. SIGNATURE Narciso W. Carmona M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/15/67	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA				22d. ADDRESS Spring Grove S. Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR. 18, 1967		23c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		23d. LOCATION (City or Town) (County) (State) DELTA, PA.	
24. FUNERAL DIRECTOR John H. Harkin, DELTA, PA.				25a. REC'D BY REGISTRAR APR 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shangri-La</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Halethorpe</u> 03-1 d. STREET ADDRESS <u>4602 Rehbaum Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>John H. Alloway</u> First Middle Last 5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>9/29/05</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY?						4. DATE OF DEATH <u>4/26</u> Month Day Year <u>1967</u> 9. AGE (In years last birthday) <u>61</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Funeral</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>John R. Alloway</u> 14. MOTHER'S MAIDEN NAME <u>Rosa E. Lugenebell</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>213-05-9266</u> 17. INFORMANT <u>Louise Alloway</u> Address <u>4602 Rehbaum Ave.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic renal cell</u> <u>180X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinoma of the kidney</u> DUE TO (c) <u>2 1/2 yrs.</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>66</u> , to <u>April 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 25</u> , 19 <u>67</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Herbert J. Lexickas</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>4/27/67</u>											
22c. PHYSICIAN'S NAME (Type) <u>Dr. Herbert Lexickas</u> 22d. ADDRESS <u>1073 Maiden Choice Lane</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>4/29/67</u> 23c. NAME OF CEMETERY OR CREMATORY <u>London Park Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>											
24. FUNERAL DIRECTOR <u>Embry Inc. 1328 Sulphur Sp. Rd.</u> 25a. REC'D BY REGISTRAR <u>APR 28 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>											

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04658

CERTIFICATE OF DEATH

04658

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21221			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital				d. STREET ADDRESS 801 Norris Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH J AMRHEIN				4. DATE OF DEATH Month Day Year April 13 1967				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/20/99		
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Millwright			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Phillip Amrhein				14. MOTHER'S MAIDEN NAME Augusta Schiefer				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 216-01-0757		17. INFORMANT Mrs. Mary M. Amrhein		Address (Same)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of left coronary artery. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 13, 1967 to April 13, 1967 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on April 13, 1967 , and that death occurred at 6:40 P.M. from causes on and on the date stated above.								
22a. SIGNATURE <i>M.S. Cockburn MD</i>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 14, 1967		
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE APR 17 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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UNITED STATES DEPARTMENT OF AGRICULTURE

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04659

CERTIFICATE OF DEATH

04659

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTO.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b 8 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO MEDICAL CENTER				d. STREET ADDRESS 225 BOSLEY AVENUE			
3. NAME OF DECEASED (Type or print) First JOSEPH Middle LYMAN Last ANDERSON SR.				4. DATE OF DEATH Month APRIL Day 5 Year 1967			
5. SEX MALE	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/18/94	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TEST GUARDMAN- RET.			10b. KIND OF BUSINESS OR INDUSTRY A. T. T. CO.		11. BIRTHPLACE (County & State, or foreign country) BALTO., Co., MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME FRANK ANDERSON				14. MOTHER'S MAIDEN NAME CECELIA ARMSTRONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 212 03 5032		17. INFORMANT Pt's History			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1221 Congestive heart failure DUE TO (b) Bronchopneumonia DUE TO (c) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4-4 , 19 67 , to 4-5 , 19 67 , that (I) (we) last saw the deceased alive on 4-5 , 19 67 , and that death occurred at 12:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Manfred Schind				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-5-67	
22c. PHYSICIAN'S NAME (Type) MARLO B INES MD				22d. ADDRESS GBMC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Apr. 8, 1967		23c. NAME OF CEMETERY OR CREMATORY DRUID RIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) PIKESVILLE, MD.	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.				25a. REC'D BY REGISTRAR DATE APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04660

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04660

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b 6 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		d. STREET ADDRESS 3612 Briarstone Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Orren Middle L. Last Andrews		4. DATE OF DEATH Month April Day 3 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/25/1886
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 2 Days 15 Hours 3 Min. 20	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired -Mfg. Rep.		11b. KIND OF BUSINESS OR INDUSTRY Auto	
12. BIRTHPLACE (State or foreign country) Penna.		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME James Andrews		15. MOTHER'S MAIDEN NAME Mabel Gessner Rosalia Adell Porter	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Unknown		17. SOCIAL SECURITY NO. 363-03-6103 A	
18. INFORMANT Hospital Chart		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 3 days post operative rt. (c) hip prosthesis			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down the basement steps	
20c. TIME OF INJURY Month, Day, Year 6:15 a.m. 3/29/ 19 67		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Randallstown, Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		22. DATE SIGNED 4-3-67	
EXAMINER'S NAME (Type) D. D. CAPLES		22. DATE SIGNED 4-3-67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/67	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge		23d. LOCATION (City or Town) (County) (State) Pikesville, 21208, Md.	
24. FUNERAL DIRECTOR Loring Byers-3728 Liberty Rd. Randallstown, Md.		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04661

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04661

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea 21206				c. LENGTH OF STAY IN 1b 17 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Overlea 031	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7549 Belair Road				d. STREET ADDRESS 7549 Belair Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frances Antczak				4. DATE OF DEATH Month Day Year 4 25 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/13/91		9. AGE (In years last birthday) 75	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Minnesota		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME August Kobaskie				14. MOTHER'S MAIDEN NAME Elizabeth Sroda			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-48-6424		17. INFORMANT (Daughter) Address Balto. Md. Mrs. Christina Borys, 7551 Belair Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Sudden DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D. EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Balto. Md. Address (Street, city, town, or county) 7501 York Rd.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/67		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS 21224 John J. Duda, Inc. 2829 Hudson St. Balto. Md.				25a. REC'D BY REGISTRAR DATE APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles J. Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04662					04662									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY			Baltimore		a. STATE			Maryland						
			MARYLAND		b. COUNTY			Prince George's						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Catonsville		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			Hyattsville, Maryland						
			1yr5mth2dys					16-2						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS									
SPRING GROVE STATE HOSPITAL					1915 Fox St. - Apt. 202									
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH									
First Middle Last					Month Day Year									
Catherine M. Ardinger					April 12 1967									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)						
female		white		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		July 5, 1911		55 yrs.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?						
housewife						Virginia		U. S.						
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME									
Winfred Dean					Effie Mills									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT			Address						
					Records: SPRING GROVE STATE HOSPITAL									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]														
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Cardiac Failure														
190X DUE TO														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bilateral Pneumonia														
DUE TO (c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)														
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year				20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)						
Hour a.m. p.m. 19				While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>										
21. I certify that (X) (this hospital) attended the deceased from Nov. 8, 1965, to April 12, 1967, that (I) (he) last saw the deceased alive on April 12, 1967, and that death occurred at P.M. from the causes and on the date stated above.														
22a. SIGNATURE					P. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED						
Evelio A. Felipe, M.D.					22d. ADDRESS			4-12-67						
					SPRING GROVE STATE HOSPITAL									
					Baltimore, Maryland 21228									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City, town or county) (State)						
Burial			4/16/67		Fairfax Memory Gardens			Fairfax Virginia						
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Howard H. Hubbard Funeral Home					APR 17 1967					J Charles Judge				
4107 Wilkens Ave.														

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04663

CERTIFICATE OF DEATH

04663

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 19 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dorothy Middle L. Last Armstrong		4. DATE OF DEATH Month April Day 9 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1913
9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months 30 Days 4	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife (cost clerk)		10b. KIND OF BUSINESS OR INDUSTRY meat packing	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Frederick Krasser		14. MOTHER'S MAIDEN NAME Theresa C. Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, or unknown) (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 212-03-7557	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 491X IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 30, 19 67 to April 9, 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 9, 19 67 , and that death occurred at 1:48 M, from causes on and on the date stated above.			
22a. SIGNATURE Evelio A. Felipe, M.D.		22b. DATE SIGNED 4-10-67	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 12, 1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cent	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR STERLING FUNERAL ESTATE 736 Edm. Av. Catonsville, Md.		25. REGISTERED BY REGISTRAR APR 12 1967	
26. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04664

CERTIFICATE OF DEATH

04664

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randalls town</u>		c. LENGTH OF STAY IN 1b <u>DOA</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp</u>		d. STREET ADDRESS <u>6509 Windsor Mill Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>M</u> Last <u>Arrington</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG 30 - 1907</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Amos Arrington</u>		14. MOTHER'S MAIDEN NAME <u>CARRIE Carr</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-03-3881</u>	
17. INFORMANT <u>Ernest Arrington</u>		18. ADDRESS <u>3519 Essex Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion (Probable)</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 2, 1948</u> to <u>4/29, 1967</u> that (I) (we) last saw the deceased alive on <u>4/29, 1967</u> , and that death occurred at <u>1 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>C. Mendelis</u>		22b. DATE SIGNED <u>4/29/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. Mendelis</u>		22d. ADDRESS <u>2308 Edmondson Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5-2-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>LAKEVIEW Memorial Cem</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>Ellsworth ARMACast-4600 Liberty Hgts Ave.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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STATE OF CALIFORNIA

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IN SENATE, January 1, 1900.

REPORT OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1899.

ALBANY, N. Y.: 1900.

W. H. BROWN, COMMISSIONER.

ALBANY, N. Y.: 1900.

W. H. BROWN, COMMISSIONER.

ALBANY, N. Y.: 1900.

W. H. BROWN, COMMISSIONER.

ALBANY, N. Y.: 1900.

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W. H. BROWN, COMMISSIONER.

ALBANY, N. Y.: 1900.

W. H. BROWN, COMMISSIONER.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04665		CERTIFICATE OF DEATH				04665			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN 1b 7 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			21234 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 1748 Joan Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Daniel Middle C. Last Backus					4. DATE OF DEATH Month April Day 5 Year 1967				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-11-93		9. AGE (In years last birthday) 73 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Balto. City Fire Dept.		11. BIRTHPLACE (County & State, or foreign country) Balto., Md.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Charles Backus					14. MOTHER'S MAIDEN NAME Ella T. Danaher				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W.11 214-24-8277		17. INFORMANT Address Mrs. Helen V. Langhirt 1748 Joan Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonitis DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Large esophageal diverticulum									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 6, 1967 , to April 5, 1967 , that (I) (we) last saw the deceased alive on April 5, 1967 , and that death occurred on April 5, 1967 , from causes and on the date stated above.									
22a. SIGNATURE Antonio Razo					22b. DATE SIGNED April 5, 1967			22c. PHYSICIAN'S NAME (Type) Antonio Razo	
22d. ADDRESS 7620 York Road- Towson 21204, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Baltimore Md.			
24. FUNERAL DIRECTOR 8521 Loch Raven B'ld.				25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

04882

04882

John T. Hammer

Operation Hammer

14-24-67 Mrs. Helen J. Hammer 1745 10th Ave

1745

Hammer, John T.

1745 10th Ave

1745 10th Ave

1745 10th Ave

1745 10th Ave

1745 10th Ave

1745 10th Ave

Hammer, John T.

Hammer, John T.

APR 10 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04666

CERTIFICATE OF DEATH

04666

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>3 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>2005 Oak Drive 21207</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>S.</u> Last <u>BAER</u>				4. DATE OF DEATH Month <u>Apr</u> Day <u>14</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-6-08</u>		9. AGE (In years lost birthday) yrs. <u>59</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>social sec.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>GUY BAER</u>				14. MOTHER'S MAIDEN NAME <u>Stahley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-10-3120</u>		17. INFORMANT <u>Ruth Agnes Baer - Same</u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>massive cerebral hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>2° to Hypertension</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>8</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-11</u> , 19 <u>67</u> , to <u>4-14</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-14</u> , 19 <u>67</u> , and that death occurred at <u>12:50 PM</u> from causes and on the date stated above.							
22a. SIGNATURE <u>J. Simon, M.D.</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-14-67</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-18-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>Elsworth Armacost - 4600 Liberty Heights Ave</u>				25a. REC'D BY REGISTRAR DATE <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. Young</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

04667

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #2b, c & d Film #G387 4/20/67 pc

CERTIFICATE OF DEATH

04667

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTIMORE</u> <u>Carroll</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Finksburg</u> <u>062</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Aged Women's & Men's Home</u>		d. STREET ADDRESS <u>Box 88</u> <u>614714 HATHAWAY</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JANE</u> <u>Bell</u> <u>Bailey</u>		4. DATE OF DEATH Month Day Year <u>April</u> <u>10</u> <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 28 1876</u>
9. AGE (In years lost birthday) <u>90</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOME MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Jamesville N.C</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ezra H Bailey</u>		14. MOTHER'S MAIDEN NAME <u>Balham, Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-46-4170</u>	
17. INFORMANT Address <u>Aged Women's & Men's Home - #2</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> DUE TO (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 9, 1967</u> , to <u>April 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 9, 1967</u> , and that death occurred at <u>4:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Newland Edward Day</u> M.D.		22b. DATE SIGNED <u>April 10, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>NEWLAND EDWARD DAY</u>		22d. ADDRESS <u>4-E-33rd ST Baltimore Md</u>	
23a. BURIAL (CREMATION, REMOVAL, SPECIFY) <u>BURIAL</u>		23b. DATE THEREOF <u>4-12-67</u>	
23c. NAME OF CEMETERY OR CREMATORIUM <u>OROLD RIDGE</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE BALT. MD</u>	
24. FUNERAL DIRECTOR <u>WM. COOK - 13 Rooks Towson</u> <u>TOWSON MD</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

MEDICAL CERTIFICATION

04887

04887

CERTIFICATE OF DEATH

General Charles G. Smith
ASCD

Merchant Marine Pay

U.S. 33-181 Program

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04668

CERTIFICATE OF DEATH

04668

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1234	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3518 Hiss Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Catherine Frances Baker		4. DATE OF DEATH Month Day Year April 23, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-9-92
9. AGE (In years last birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Eugene Bena		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-07-3108	
17. INFORMANT Mr. Robert N. Baker		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Thrombosis (left) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Congestive Heart Failure -Class IV DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 21 , 19 67 , to April 23, 1967 , that (I) (we) last saw the deceased alive on April 23, 1967 , and that death occurred at 4:20AM , from causes and on the date stated above.			
22a. SIGNATURE Efraim L. Reyes		22b. DATE SIGNED April 23, 1967	
22c. PHYSICIAN'S NAME (Type) Efraim L. Reyes		22d. ADDRESS 7620 York Road -Towson-21204, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67.	
23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR APR 24 1967	
25b. REGISTRAR'S SIGNATURE Charles J. J...			

2020

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
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VR A15 (M)
15M 7-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04669					04669						
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)						
a. COUNTY		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			a. STATE		b. COUNTY				
BALTIMORE		BALTIMORE			MARYLAND		BALTIMORE				
c. LENGTH OF STAY IN 1b		d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS				
BALTIMORE		2705 Woodcourt Road			BALTIMORE		2705 Woodcourt Road				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. IS RESIDENCE ON A FARM?		6. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
First Middle Last					Date		Month Day Year				
JACOB					BECKER		4 4 1967				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (in years last birthday)			
MALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		JULY 1892		74 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
RETIRED					BUTCHER		RUSSIA		U.S.A.		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME						
MENDEL					SARAH						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)					16. SOCIAL SECURITY NO.		17. INFORMANT Address				
							MINNIE B. HYATT - 2705 Woodcourt Rd.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]								INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)											
4200 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) Anemic											
(c) Secondary Anemioleucemia											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
Inch. Lip 1 year ago -											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>							
21. I certify that (I) (this hospital) attended the deceased from April 1, 1966, to April 4, 1967, that (I) (we) last saw the deceased alive on April 4, 1967, and that death occurred at 3:45 AM, from the causes and on the date stated above.											
22a. SIGNATURE					22b. DATE SIGNED						
Nathan E. Needle, M.D.					April 4/67						
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS						
NATHAN E. NEEDLE, M.D.					6506 Park Heights Dr. - Baltimore						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
BURIAL		4/5/1967		ROSEDALE		BALTIMORE MD					
24. FUNERAL DIRECTOR'S SIGNATURE					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
SYLVAN S. LEWIS & SON, INC. GARRISON, MD					APR 5 1967		Charles Judge				

6056

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04670

CERTIFICATE OF DEATH

04670

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Hunter Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Rosa S. Bell		4. DATE OF DEATH Month Day Year April 25 19 67	
5. SEX F	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 14, 1883
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late - William H. Birkett		14. MOTHER'S MAIDEN NAME Late - Willie Mason	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Joseph W. Armiger 225 Burke Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Crown thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis Cardio Vase DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cancer of face Hydrochloric anemia			INTERVAL BETWEEN ONSET AND DEATH instantaneous
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 7/28 , 19 62 , to 4/25 , 19 67 , that (I) (we) last saw the deceased alive on 4/22 , 19 67 , and that death occurred at C.P.M. from causes and on the date stated above.			
22a. SIGNATURE Cliff Ratliff, Jr.		22b. DATE SIGNED 4/26/67	
22c. PHYSICIAN'S NAME (Type) Cliff Ratliff, Jr.		22d. ADDRESS 4605 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-28-67	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Witzke F. D. - 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE APR 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05370

RECORD OF DEATH

05370

Elizabet City
300 Maryland Rd.

Summit Nursing Home

Rose, J. C. 1908

March 14, 1983 24

Code X

USA

Elizabet, NJ

Housewife

Married - Willie Mason

Married - William H. Minkoff

Wm. C. Mason, Jr.
1001 10th Ave.

1005 Edmondson Ave.

Cliff Minkoff, Jr.

Elizabet, NJ

Summit Park Cem.

1-1983

Period

1005 Edmondson Ave.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04671

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04671

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2 FLAGSHIP RD</u>				d. STREET ADDRESS <u>3 EASTSHIP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>RENA</u> Middle <u>BENDER</u> Last <u>BENDER</u>				4. DATE OF DEATH <u>APRIL 28</u> 19 <u>67</u> Month Day Year			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APR 23 1888</u> 29 yrs.	
9. AGE (In years last birthday) <u>79</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>HENRY BETZ</u>			
14. MOTHER'S MAIDEN NAME <u>JULIA PUGH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>MRS RUTH ROCK - 2 FLAGSHIP</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>A-S-C-V-Disease</u> DUE TO (c) <u>?</u>				INTERVAL BETWEEN DEATH AND DEATH <u>?</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>M.B. Davis</u>		EXAMINER'S NAME (Type) <u>M.B. DAVIS</u>		M.D. <u>M.D.</u>		22. DATE SIGNED <u>4/29/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 1, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION (City or Town) (County) (State) <u>COLGATE MD</u>	
24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME - DUNDALK MD</u>				25a. REC'D BY REGISTRAR <u>MAI 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

17330

17330

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04672

CERTIFICATE OF DEATH

04672

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 4017 Biddison Lane		
3. NAME OF DECEASED (Type or print) First Middle Last Jacqueline Elizabeth BENNETT			4. DATE OF DEATH Month Day Year April 26, 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1967		9. AGE (In years lost birthday) yrs. 7
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Norman Michael Bennett			14. MOTHER'S MAIDEN NAME Marlene Yvonne Manzione		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address MR. NORMAN N. BENNETT (SAME)		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Previabie premature 776X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19, 19 67 to April 26, 19 67 , that <input checked="" type="checkbox"/> (we) lost the deceased alive on April 26, 19 67 , and that death occurred at 3:15M , from causes and on the date stated above.					
22a. SIGNATURE Jose Aguto		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 26, 1967	
22c. PHYSICIAN'S NAME (Type) Jose Aguto, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/27/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) BALTIMORE Md.	
24. FUNERAL DIRECTOR LEONARD J. RUCK, INC. BALTO. Md. 21214		25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04478

UNITED STATES OF AMERICA

04478

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04673

CERTIFICATE OF DEATH

04673

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY CARROLL ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER	
c. LENGTH OF STAY IN 1b 14 DAYS		d. STREET ADDRESS E. GREEN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMORY Middle RAYMOND Last BLIZZARD		4. DATE OF DEATH Month APRIL Day 1 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/5/02
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SIGN DISPLAYER		10b. KIND OF BUSINESS OR INDUSTRY NAT'L. ADVERT. CO.	
11. BIRTHPLACE (County & State, or foreign country) CARROLLTON, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JEREMIAH BLIZZARD		14. MOTHER'S MAIDEN NAME ELLEN MARTIN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWII		16. SOCIAL SECURITY NO. 214 03 73 61	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG WITH METASTASES 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 18, 1967 to APRIL 1, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 1, 1967 , and that death occurred at 2:00 PM , from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 4/1/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/4/67	
23c. NAME OF CEMETERY OR CREMATORY CARROLLTON CHURCH CEMETERY		23d. LOCATION (City or Town) (County) (State) CARROLLTON, CARROLL, MD.	
24. FUNERAL DIRECTOR SAFFELL, FUNERAL HOME,		25a. REC'D BY REGISTRAR APR 3 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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04674

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04674

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>39 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Creater Baltimore Medical Center</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Joshua Galbatt Booth</u>		4. DATE OF DEATH <u>4/19/67</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cauc</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/19/88</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BO Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Henry Walter Booth</u>		14. MOTHER'S MAIDEN NAME <u>Galbatt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>705-104431</u>	
17. INFORMANT <u>Patience Chart</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4321 Congestive heart failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent abdom. surgery for colon cancer</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 11</u> , 19 <u>67</u> , to <u>April 19</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 19</u> , 19 <u>67</u> , and that death occurred at <u>1:50 P</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>M. Isabelle MacGregor M.D.</u>		22b. DATE SIGNED <u>4-19-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ISABELLE MACGREGOR</u>		22d. ADDRESS <u>Creter Baltimore Medical Center</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 22, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Carrollton Bethel</u>	23d. LOCATION (City or Town) (County) (State) <u>Carrollton, Carroll Cty. Md.</u>
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>1050 York Road Towson, Maryland 21204</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>APR 21 1967</u>	

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Recent address: university for color sciences

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04675

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04675

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21222</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21222</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>7546 Rabon Ave.</u>		d. STREET ADDRESS <u>7546 Rabon Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>First Jesse Middle Bowers Last BOWERS</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>24</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1917</u>
9. AGE (In years last birthday) <u>50</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Factory Guard & Mgr. Bowling Bus.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joshua Bowers</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jefferson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes</u> <u>W.W. II</u>		16. SOCIAL SECURITY NO. <u>215-07-6980</u>	
17. INFORMANT <u>Mrs. Charlotte E. Bowers-7546 Rabon Ave.</u>		Address <u>Balt. 21222</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Theo C Patterson</u> EXAMINER'S NAME (Type) <u>THEO C PATTERSON</u>		22. DATE SIGNED <u>4/24/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/27/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>		23d. LOCATION (City, town or county) (State) <u>6 E. Franklin St. Balt. 21202</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown</u>		25a. REC'D BY REGISTRAR <u>APR 27 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04676

CERTIFICATE OF DEATH

04676

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reattach carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CARNEY</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>9744 MagLeet Rd</u>		d. STREET ADDRESS <u>9744 MagLeet Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>R</u> Last <u>Bowling</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>29</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 20 1902</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <u>64</u> yrs.
11. BIRTHPLACE (County & State, or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles E. Rankin</u>		14. MOTHER'S MAIDEN NAME <u>Violet H. Howe</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-22-4813</u>	
17. INFORMANT <u>Family records</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic Anemia with</u> DUE TO <u>Congestive heart Failure due to</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>above</u> DUE TO (c) <u>Generalized Carcinomatosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Origin Ovarian Carcinoma</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> to <u>April</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/27</u> 19 <u>67</u> , and that death occurred at <u>6 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>J. Kasik Jr M.D.</u>		22b. DATE SIGNED <u>5/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>F.T. KASIK JR.</u>		22d. ADDRESS <u>9005 Harford Rd.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>5/2/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>C.F. EVANS & SON 8802 Harford Bd.</u>		25a. REC'D BY REGISTRAR DATE <u>MAY 3 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04677

CERTIFICATE OF DEATH

04677

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Donneybrook			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Donneybrook 13-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 300 Garden Rd.				d. STREET ADDRESS 300 Garden Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EARL T. BRADDOCK First Middle Last				4. DATE OF DEATH April 3rd , 19 67 Month Day Year			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH August 4, 1895.	
9. AGE (In years and birthday) 71 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (County & State, or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert Braddock				14. MOTHER'S MAIDEN NAME Lillie May Taylor			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk. (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-07-9611		17. INFORMANT Address Mrs. Norma L. Braddock (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H.A.S.C.V.D. & old left C.V.A. (hemiplegia) DUE TO (c) 2 YRS							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from JULY , 19 58 , to APRIL , 19 67 , that (I) (we) last saw the deceased alive on APRIL 2 , 19 67 , and that death occurred at 130 PM , from causes and on the date stated above.							
22a. SIGNATURE Carlton L. Sexton				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-4-67	
22c. PHYSICIAN'S NAME (Type) Carlton L. Sexton, M.D.				22d. ADDRESS 819 Park Ave., Baltimore, Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/6/67.		23c. NAME OF CEMETERY OR CREMATORY Silver Run Brook Cemetery		23d. LOCATION (City or Town) (County) (State) Wilmington, Delaware.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14				25a. REC'D BY REGISTRAR DATE APR 4 1967		25b. REGISTRAR'S SIGNATURE f Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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04678

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04678

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY -			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Spring Grove State Hospital				d. STREET ADDRESS ?		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle Brandt Last Brandt				4. DATE OF DEATH Month April Day 28 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1890?		9. AGE (In years birth day) yrs. 77	IF UNDER 1 YEAR Months 1 Days 17 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Unkown				14. MOTHER'S MAIDEN NAME Unkown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 219-54-3038		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis, generalized and severe 4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Malnutrition and dehydration							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that it (this hospital) attended the deceased from August 14, 1960 , to April 28, 1967 , that it (we) last saw the deceased alive on April 28, 1967 , and that death occurred at 1:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Stella Wachsler				ATTENDING MED. PHYS. <input checked="" type="checkbox"/> P. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-28-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachsler, M.D.				22d. ADDRESS Spring Grove State Hospital Catonsville, Maryland 21228			
23a. BURIAL, CREMATION, OR OTHER DISPOSAL (Specify)		23b. DATE THEREOF 5 May 67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City or Town) (County) (State) Old Frederick Road Baltimore	
24. FUNERAL DIRECTOR Kraus Funeral Home 12165 Charles				25a. REC'D BY REGISTRAR MAY 8 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04679

CERTIFICATE OF DEATH

04679

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Florida b. COUNTY 483	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson - 4		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) M. First Middle Last (Sister Saint Dorothy OSF) BRENNAN		4. DATE OF DEATH Month April Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-15-15
9. AGE (In years last birthday) 51 50 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Religious		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George J. Brennan		14. MOTHER'S MAIDEN NAME Elizabeth G. Williamson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Sister Margaretta, St. Joseph's Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Carcinoma due to Ca. of Ovary 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 7 th , 1967 pm April 17 , 1967, that (I) (we) last saw the deceased alive on April 17 th 1967, and that death occurred at 11:10 M, from causes and on the date stated above.			
22a. SIGNATURE Freidoon Malek M.D.		22b. DATE SIGNED April 17, 1967	
22c. PHYSICIAN'S NAME (Type) Freidoon Malek M.D.		22d. ADDRESS 7620 York Road, Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/67.	
23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE APR 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04680

Item #13 Film #G388 5/3/67 ps

CERTIFICATE OF DEATH

04680

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville TOWSON			c. LENGTH OF STAY IN 1b 			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 9607 Harding Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED First Middle Last Arthur B. Bridges				4. DATE OF DEATH Month Day Year April 22 19 67					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH 9-4-84		9. AGE (In years last birthday) 82 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Steamfitter				10b. KIND OF BUSINESS OR INDUSTRY H.E. Crook		11. BIRTHPLACE (County & State, or foreign country) Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME UNKNOWN/ Issias Bridges				14. MOTHER'S MAIDEN NAME Mary *****					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW2			16. SOCIAL SECURITY NO. 214-01-7502		17. INFORMANT Address Hospital records				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pneumonia - bilateral								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from March 17, 19 67 , to April 22, 19 67 , that (I) (we) last saw the deceased alive on April 22, 19 67 , and that death occurred at 5:30A AM, from causes and on the date stated above.									
22a. SIGNATURE Efrain L. Reyes M.D.						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 22, 1967	
22c. PHYSICIAN'S NAME (Type) Efrain L. Reyes M.D.						22d. ADDRESS 7620 York Road-Towson 21204, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood cemetery		23d. LOCATION (City or Town) (County) (State) Parkville, Balto Md.			
24. FUNERAL DIRECTOR CHAS. F. EVANS + Son				ADDRESS 8802 Harford Rd		25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04681

04681

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 7yr4mth25dys			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL				e. STREET ADDRESS 5517 Nicholson Street			
3. NAME OF DECEASED (Type or print) First Margaret Middle Mary Last Brosnan				4. DATE OF DEATH Month April Day 22 Year 1967			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1893	
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Timothy Warren				14. MOTHER'S MAIDEN NAME MaryLeane			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 213 50 8678		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized Arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH 20 days 8 years 10 "
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus, Pneumonia, Arteriosclerotic Endarteritis							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. 25, 1959 , to 4/22, 1967 , that (I) (we) last saw the deceased alive on 4/22/67 19 67 , and that death occurred at 1:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE Narciso W. Carmona				22b. DATE SIGNED 4/23		22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA	
22d. ADDRESS SPRING GROVE STATE HOSPITAL				22e. ADDRESS Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem.		23d. LOCATION (City, town or county) (State) Silver Spring, Maryland	
24. FUNERAL DIRECTOR Tyson Wheeler		24a. ADDRESS Funeral Home 1551 Rock. Pike		24b. ADDRESS Rockville, Maryland		24c. DATE APR 25 1967	
24d. SIGNATURE Charles J. J...		24e. REGISTRAR'S SIGNATURE Charles J. J...					

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BEING MADE BY THE
FALL - 1904, 1905, 1906

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04682

CERTIFICATE OF DEATH

04682

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>_____</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>30.4</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>1302 E. Belvedere Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>Philip</u> Middle <u>E.</u> Last <u>Buckey</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 12, 1890</u>
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>_____</u> Days <u>_____</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Sales Manager</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Sales</u>	
13. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md</u>		14. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. FATHER'S NAME <u>Jacob Buckey</u>		16. MOTHER'S MAIDEN NAME <u>Amelia Runge</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		18. SOCIAL SECURITY NO. <u>212-10-8007A</u>	
19. INFORMANT <u>Mrs Pauline Buckey</u>		Address <u>same</u>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>H A S H D</u> DUE TO (c) <u>_____</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>57 can</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>_____</u> o.m. <u>19</u> p.m. <u>_____</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>36</u> , to <u>4/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/15</u> , 19 <u>67</u> , and that death occurred at <u>3P</u> M, from causes and on the date stated above			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. I. S. Zinberg</u>		22d. ADDRESS <u>4000 W. Northwood Parkway</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4/19/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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VR A15 (4)
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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04683

CERTIFICATE OF DEATH

04683

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>(R) Towson</u>		c. LENGTH OF STAY IN 1b <u>16 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Bowleys Quarters</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Medical Center</u>				d. STREET ADDRESS <u>5428 Sineen Pk Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>NNN</u> Last <u>BUCZEK</u>				4. DATE OF DEATH Month <u>4</u> Day <u>21</u> Year <u>1967</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>Can</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-19-05</u>		9. AGE (In years last birthday) <u>61</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Assembler</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Delta Aluminum Co</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Louis Buczek</u>				14. MOTHER'S MAIDEN NAME <u>Sophie Pomykala</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>None</u> <u>no</u>		16. SOCIAL SECURITY NO. <u>219-10-4458</u>		17. INFORMANT <u>Taken from Pt's chart (D. Moser R.N.)</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> <u>1021</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Bronchogenic carcinoma with</u> DUE TO <u>carcinomatosis</u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-5-</u> , 19 <u>67</u> , to <u>4-21-</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-21-</u> 19 <u>67</u> , and that death occurred at <u>1:40 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>R. K. CHILLAR</u>				22b. DATE SIGNED <u>4-21-67</u>		22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHILLAR</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Dundalk, Balto. Md.</u>	
24. FUNERAL DIRECTOR <u>John J. Duda, 7922 Wise Ave. Dundalk, Md.</u>				25a. REC'D BY REGISTRAR <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04684

CERTIFICATE OF DEATH

04684

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 36yr2mth6dys			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS Box 46		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Virginia Last Bullock				4. DATE OF DEATH Month April Day 10- Year 19 67			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 22, 1884	
9. AGE (In years last birthday) yrs. 82		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY home		11. BIRTHPLACE (County & State, or foreign country) Georgia Richmond, Va.	
12. CITIZEN OF WHAT COUNTRY? U. S.				13. FATHER'S NAME Thomas Knox			
14. MOTHER'S MAIDEN NAME Mary ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 219-54-3049				17. INFORMANT JL Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Arteriosclerotic heart disease DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from Feb. 4, 19 31 to April 10, 19 67 , that (X) (we) last saw the deceased alive on April 10, 19 67 , and that death occurred on 11:15 M, from causes and on the date stated above.							
22a. SIGNATURE <i>Evelio A. Felipe</i>			22b. DATE SIGNED 4-11-67			22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.	
22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			22e. REC'D BY REGISTRAR APR 14 1967				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF April 14, 1967		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery		23d. LOCATION (City or Town) (County) (State) Arlington Va
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.			25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>				

MEDICAL CERTIFICATION

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IN REPLY TO BEAM

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04685 CERTIFICATE OF DEATH 04685

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Upperco (Rural)</u>	
c. LENGTH OF STAY IN lb <u>18 yrs</u>		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Russell</u> Middle <u>Leslie</u> Last <u>Burke</u>		4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 15 - 1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Carpenter</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Philmore Burke</u>		14. MOTHER'S MAIDEN NAME <u>Camellia Jane Frouble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>World War I</u>		16. SOCIAL SECURITY NO. <u>217-05-1076</u>	
17. INFORMANT <u>Margie May Burke</u>		Address <u>Upperco Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>10 M.D.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma Prostate</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/15</u> , 19 <u>66</u> , to <u>4/15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>67</u> , and that death occurred at <u>20</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>W. H. Foard</u>		22b. DATE SIGNED <u>4/15/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. Foard MD</u>		22d. ADDRESS <u>MANCHESTER, MD 21102</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/18/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Upperco, Md.</u>	
24. FUNERAL DIRECTOR <u>Tipton - Eline Funeral Home Hampstead, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 18 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04082

04082

Date

Time

APR 18 1967

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04686					04686					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY Baltimore MARYLAND					a. STATE Virginia					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Baltimore					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Galax					
c. LENGTH OF STAY IN 1b one week					d. STREET ADDRESS Route #4					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Shady Nook Nursing Home 1002 N. Roßling Rd					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) ADDIE BURNETTE					4. DATE OF DEATH Month April Day 4 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1904		9. AGE (In years last birthday) 62 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA		IF UNDER 1 YEAR Months Days Hours Min.		
13. FATHER'S NAME Elisha Bane Bedsaul					14. MOTHER'S MAIDEN NAME Mary Ellen Ward					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No					16. SOCIAL SECURITY NO. 224-46-7188		17. INFORMANT Vaughn-Guynn Funeral Home Galax, Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized Metastatic Carcinoma DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 17 ds. 2 yrs.										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19					20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8-30, 1963 , to 4-4, 1967 , that (I) (we) last saw the deceased alive on 4-2-1967 , and that death occurred at 2 P.M. from the causes and on the date stated above.										
22a. SIGNATURE Wilmer K. Ballager					22b. DATE SIGNED 4-4-67					
22c. PHYSICIAN'S NAME (Type) Wilmer K. Ballager					22d. ADDRESS 6209 Frederick St. Balt. 28228, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal					23b. DATE THEREOF 4-4-67		23c. NAME OF CEMETERY OR CREMATORY Carroll Co., Va.		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Inc. Baltimore, Md. 21202					ADDRESS 1217 St. Paul St.		25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

28319

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B'ONE

12. 1037. 4221

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR AIS (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>4</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>04687</p> </div> <div> <p>CERTIFICATE OF DEATH</p> <p>04687</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Howard</u> <u>Baltimore</u> <u>MARYLAND</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Howard</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicottville</u>						c. LENGTH OF STAY IN 1b <u>Ellicott City</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Summitt Nursing Home</u>						d. STREET ADDRESS <u>803 Maple Rock Road</u>					
3. NAME OF DECEASED (Type or print) First <u>MURIEL</u> Middle <u>AGNES</u> Last <u>BUTLER</u>						4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>1967</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <u>Jan. 7, 1915</u>		9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Arkansas</u>				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Samuel Meintzer</u>						14. MOTHER'S MAIDEN NAME <u>Muriel Nowack</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Alfred Butler, 803 Maple Rock Road, E.C. Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> <u>170X</u> DUE TO (b) <u>METASTATIC BRAIN CANCER</u> DUE TO (c) <u>CARCINOMA, BREAST</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>11-10</u> , 19 <u>66</u> , to <u>4-15</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>67</u> , and that death occurred at <u>7²³</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Peter V. Thode</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>4-17-67</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4-18-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City, town or county) (State) <u>Ellicott City, Md</u>			
24. FUNERAL DIRECTOR <u>F.C. Higginbotham, Ellicott City, Md</u>						25a. REC'D BY REGISTRAR <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

0383

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04688

CERTIFICATE OF DEATH

04689

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN lb <u>67 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>8056 Roslyn Avenue</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>8056 Roslyn Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Virgil</u> Middle <u>Manning</u> Last <u>Case</u>				4. DATE OF DEATH Month <u>4</u> Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/6/18</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronics</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Martin Marietta</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Dana, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Case</u>				14. MOTHER'S MAIDEN NAME <u>Tabor, Fola Belle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>399-16-2232</u>		17. INFORMANT <u>Patient Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic adenocarcinoma</u> <u>1930</u> DUE TO <u>of the brain.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>February 11</u> , 19 <u>67</u> , to <u>April 18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 18</u> , 19 <u>67</u> , and that death occurred at <u>12:10</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>M. Isabelle MacGregor</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-18-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ISABELLE MACGREGOR</u>				22d. ADDRESS <u>Gr. Baltimore Medical Center</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/21/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Philip F. Crach</u>				ADDRESS <u>1211 Chesaco Ave.</u>		25a. REC'D BY REGISTRAR <u>APR 20 1967</u>	
						25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	

04558

CERTIFICATE OF DEATH

04558

John Robert Clark

Thompson Case

Electrician, Portland, Oregon

M. C. Clark

3/6/18

49

Thompson Case

Electrician, Portland, Oregon

Thompson Case

Electrician, Portland, Oregon

Thompson Case

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04689

CERTIFICATE OF DEATH

04690

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Towson		c. LENGTH OF STAY IN lb Several Weeks	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1514 Winford Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Sarah Coalla Chancey		4. DATE OF DEATH Month Day Year April 11, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-5-08
9. AGE (In years last birthday) 59 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Alfred Doyle		14. MOTHER'S MAIDEN NAME Lelia Virginia Grimes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no no		16. SOCIAL SECURITY NO. 262-60-9785	
17. INFORMANT Brig. H.G. Chancey (husband)		Address 1514 Winford Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Lungs DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 25, 1967 , to April 11, 1967 that (I) (we) last saw the deceased alive on April 11, 1967 , and that death occurred at 2:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Teodoro Paglinawan Jr.		22b. DATE SIGNED April 11, 1967	
22c. PHYSICIAN'S NAME (Type) Teodoro Paglinawan Jr. M.D.		22d. ADDRESS 7620 York Road, Towson 21204, Maryland.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF Apr-14-67	23c. NAME OF CEMETERY OR CREMATORY West View	23d. LOCATION (City or Town) (County) (State) Atlanta, Ga.
24. FUNERAL DIRECTOR Stewart & Mowen Co 108-W-North-Av. 21201		25a. REC'D BY REGISTRAR APR 14 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09340

09340

James P. [illegible]

1991

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04690

CERTIFICATE OF DEATH

04691

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rodgers Forge</u> 13.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>70 Dunkirk Rd.</u>		d. STREET ADDRESS <u>70 Dunkirk Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Arthur Edward Chandler</u>		4. DATE OF DEATH Month Day Year <u>April 7, 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 23, 1887</u>
9. AGE (In years last birthday) <u>79</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steward</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Keswick Corp.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>London, England</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Chandler</u>	
14. MOTHER'S MAIDEN NAME <u>Phoebe</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>Yes WW I</u>	
16. SOCIAL SECURITY NO. <u>109-03-4896</u>		17. INFORMANT Address <u>A. Mrs. Emily Chandler Same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u> <u>15 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>4:00</u> April <u>7</u> p.m. <u>1967</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>65</u> , to <u>7 Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>6 Apr</u> , 19 <u>67</u> , and that death occurred at <u>4 P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Robert E. Mason</u> M.D.		22b. DATE SIGNED <u>APR 10 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert E. Mason</u>		22d. ADDRESS <u>9 E. Chase St. Baltimore</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>4-8-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14310

6P320

FOR STATE
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (3)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04691

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04692

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Catonsville		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 211 Altamont Ave. 21228				d. STREET ADDRESS 211 Altamont Ave. 21228		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last Clary				4. DATE OF DEATH Month April Day 18 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/27/98	
9. AGE (In years lost birthday) yrs. 68		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office worker-retired				10b. KIND OF BUSINESS OR INDUSTRY Geo. P. Thomas Co.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Nicholas B. Clary				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 216-05-7839		17. INFORMANT E. Carl Horst Address 211 Altamont Ave. 21228			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident - 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE James N. Frederick		22. DATE SIGNED 4/18/67					
EXAMINER'S NAME (Type) James N. Frederick -1311 Francis Ave		23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard				ADDRESS 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR APR 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04692

CERTIFICATE OF DEATH

04693

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in lb 13 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 633 South Pulaski St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Catherine Middle Elizabeth Last Coburn			4. DATE OF DEATH Month April Day 6 Year 19 67		
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1895		9. AGE (In years birthday) 71 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.
13. FATHER'S NAME Wilbur Kerbe			14. MOTHER'S MAIDEN NAME Elizabeth Bolandt		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) unknown		16. SOCIAL SECURITY NO. 217-54-0436	17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 490X DUE TO Cardiac failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic brain syndrome assoc. with cerebral arteriosclerosis					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 23, 19 67 , to April 6, 19 67 that (I) <input checked="" type="checkbox"/> saw the deceased alive on April 6, 19 67 , and that death occurred at 1:25 M, from causes and on the date stated above.					
22a. SIGNATURE <i>Evelio A. Felipe</i>		22b. DATE SIGNED 4-6-67		22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 21229 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR APR 10 1967	25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>

MEDICAL CERTIFICATION

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ST. JOHN'S HOSPITAL

ST. JOHN'S HOSPITAL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04693

CERTIFICATE OF DEATH

Reg. Dist. No. 04694

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BUTLER</u>		c. LENGTH OF STAY IN TB <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Butler Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Charles M. Cole</u>		4. DATE OF DEATH Month Day Year <u>April 8 1967</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN 9 1893</u>
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	
11. BIRTHPLACE (State or foreign country) <u>Butler Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George R Cole</u>		14. MOTHER'S MAIDEN NAME <u>Laura Martin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-23-9254</u>	
17. INFORMANT <u>Nellie Cole</u>		Address <u>BUTLER MD</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Stomach (Primary)</u> 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>February 5 1965</u> to <u>Apr 8 1967</u> , that I last saw the deceased alive on <u>March 28 1967</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>HAMPSTEAD MD 4-8-67</u>			
ACTUAL SIGNATURE <u>Joseph E. Bush MD</u>		PHYSICIAN'S NAME (Type) <u>Joseph E. Bush MD HAMPSTEAD MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>4/11/67</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Black Rock Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Butler, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Tipton - Eline Funeral Home</u>		ADDRESS <u>Hampstead, Md.</u>	
DATE <u>APR 11 1967</u>		DATE <u>APR 11 1967</u>	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04694

CERTIFICATE OF DEATH

04695

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY in 1b 35 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THEODORE Middle (NMI) Last COLE				4. DATE OF DEATH Month APRIL Day 18 Year 1967			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/22/94	9. AGE (In years last birthday) 72	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Home Construction		11. BIRTHPLACE (County & State, or foreign country) Frederick City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Cole				14. MOTHER'S MAIDEN NAME Laura Brown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-12-03-09		17. INFORMANT Clin.Rec. VAH, Fort Howard, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOGENIC CARCINOMA LEFT LUNG WITH METASTASES DUE TO (c) UNKNOWN							INTERVAL BETWEEN ONSET AND DEATH RECENT
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROSIS GENERALIZED. BENIGN PROSTATIC HYPERTROPHY. EMACIATION							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from March 14 , 19 67 , to April 18 , 19 67 that 10 (we) last saw the deceased alive on April 18 , 19 67 , and that death occurred 5:25 AM , from causes and on the date stated above.							
22a. SIGNATURE J. D. Talbert				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.	
22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-21-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Chas. O. Wilson		25a. REC'D BY REGISTRAR APR 20 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

04034

Baltimore

Fort Howard

35 Days

Veterans Administration Hospital

Baltimore

1132 N. Broadway Street

Male

Colored

5/22/51

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Lab. Test

Home Investigation

Frederick City, Md.

U.S.A.

John Cole

Barry Brown

Yes

WM I

715-12-0-02 of 100, V.H. Fort Howard, B. 12/1/50

INVESTIGATION

INVESTIGATION CAROLINA EAST BORN WITH PHENYLKETONURIA

ARTIFICIALLY INDUCED GIBBERIC ACID, WHICH PRODUCE SYMPTOMATICS. INVESTIGATION

APRIL 10 1951

RECEIVED IN

APRIL 10 1951

AT HOSPITAL, FORT HOWARD, BALTIMORE

INVESTIGATION, BALTIMORE

INVESTIGATION, BALTIMORE

APRIL 20 1951

INVESTIGATION, BALTIMORE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04695

CERTIFICATE OF DEATH

Reg. Dist. No. 04696

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Paradisee Nursing Home				e. STREET ADDRESS 2132 Oakland Ave.			
3. NAME OF DECEASED (Type or print) First Elinor M. Middle Colison Last				4. DATE OF DEATH Month 4/26/67 Day 19 Year			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?				14. MOTHER'S MAIDEN NAME ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes No		16. SOCIAL SECURITY NO. 216-36-6784		17. INFORMANT Walter M. Colison 902 Essex Sq.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4221 Acute & Chronic Congestive Heart Failure DUE TO (b) Failure (c) Arterio Sclerotic Cardio Vascular Disease DUE TO (d) Residuals of Pulmonary Tuberculosis				INTERVAL BETWEEN ONSET AND DEATH 1 yr. 10 yrs. 15 yrs.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 0021 thoracoplasty left old				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/5/67 , 19 67 , to 4/26/67 , 19 67 , that I last saw the deceased alive on 4/25/67 , 19 67 , and that death occurred at 12:55 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1303 Fridman Rd DATE SIGNED 4/28/67 ACTUAL SIGNATURE W E Mc Grath MD M.D. Catonsville 28md PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF April 29, 1967		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul E. Chonoweth 3rd				ADDRESS 3617 Chestnut Ave.		24a. REC'D BY REGISTRAR MAY 2 1967	
				24b. REGISTRAR'S SIGNATURE Charles Judge			

05888

CERTIFICATE OF DEATH

05888

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04696

Item 3 Film c388 5/11/67 kk

CERTIFICATE OF DEATH

04688

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 34yrlmthl9dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 617 Madison Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Colavino Last Callabina				4. DATE OF DEATH Month April Day 28 Year 19 67			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> separated <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1899		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? Italy	
13. FATHER'S NAME Anthony Rizzo				14. MOTHER'S MAIDEN NAME Cecelia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Congestive heart failure DUE TO (b) Pneumonia Right Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Dec. 9 , 19 67 to April 28 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 28 , 1967, and that death occurred at 6:35 P. M., from causes and on the date stated above.							
22a. SIGNATURE Anthony J. Young, M.D.				22b. DATE SIGNED 5-1-67		22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/4/67		23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL		23d. LOCATION (City or Town) (County) (State) WILMINGTON, DEL.	
24. FUNERAL DIRECTOR Spencer Mulliken F.H.				25a. REC'D BY REGISTRAR MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

Dr. E. B. Mc Nab

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CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

PLACE OF BIRTH

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DATE OF BIRTH

Handwritten notes and signatures in the lower section of the form.

DATE OF DEATH

PLACE OF DEATH

DATE OF BIRTH

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PLACE OF BIRTH

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04697

04697

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Eastonville</u> c. LENGTH OF STAY IN 1b <u>22 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>House On The Pines</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>_____</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>53 So. Carrollton Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Nola</u> Middle <u>E.</u> Last <u>Colquith</u>		4. DATE OF DEATH Month <u>4</u> Day <u>29</u> Year <u>1967</u>		5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-31-01</u>		9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u>_____</u> Days <u>_____</u> IF UNDER 24 HRS.: Hours <u>_____</u> Min. <u>_____</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>seamstress</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Clothing Co</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Edw. Faulkner</u>						14. MOTHER'S MAIDEN NAME <u>Anne Elizabeth</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>_____</u>				17. INFORMANT Address <u>226 Beth Rd</u> <u>Mrs Doris Henderson Collins Ave</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>_____</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus</u>												INTERVAL BETWEEN ONSET AND DEATH <u>7 hr</u> <u>10 yr</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>_____</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from <u>2-7-1967</u> to <u>4-29-1967</u> , that (I) (we) last saw the deceased alive on <u>4-28-1967</u> , and that death occurred at <u>3:55</u> M. from the causes and on the date stated above.															
22a. SIGNATURE <u>Wilmer K. Gallager</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> M.D.		22b. DATE SIGNED <u>5/1/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Wilmer K. Gallager</u>		22d. ADDRESS <u>6209 Frederick Ave. Balt. Md. 21228</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>5/3/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cem.</u>				23d. LOCATION (City, town or county) (State) <u>3310 Taylor Ave Md.</u>					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Curran & Son Inc.</u>						ADDRESS <u>20 Hollis St.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

23, Md.

08223

STATE OF NEW YORK
JUDICIAL DEPARTMENT
SUPREME COURT
IN SENATE
JANUARY 1967

08223

3

3

3

3

3

3

MAY 2 1967

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MATYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04698

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04698

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown c. LENGTH OF STAY IN 1b Randallstown		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hospital		d. STREET ADDRESS 2833 Riggs Avenue 21216	
3. NAME OF DECEASED (Type or print) JACKIE COVINGTON		4. DATE OF DEATH Month 4 Day 23 Year 19 67	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/27/49
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY NO SPECIAL ONE	9. AGE (In years last birthday) 17 yrs.
11. BIRTHPLACE (State or foreign country) N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME GRADY COVINGTON		14. MOTHER'S MAIDEN NAME DOROTHY KNEIGHT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT DOROTHY COVINGTON		Address 2833 Riggs Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest 982X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed in chest	
20c. TIME OF INJURY Month, Day, Year 7:45 p.m. 4 23 1967	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Gwynn Oak Park	20f. (City or town) (County) (State) Baltimore Balto. Md.
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 4-24-67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/28/67	23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn	23d. LOCATION (City or Town) (County) (State) Balto. Md.
24. FUNERAL DIRECTOR Wm. E. Chatman - 1701 Mt. Cullloch St		25a. REC'D BY REGISTRAR APR 26 1967	25b. REGISTRAR'S SIGNATURE J. Charles Judge

55

MEDICAL CERTIFICATION

04558

04558

1955 R. R. Avenue, 1010

1955 R. R. Avenue, 1010

1955 R. R. Avenue, 1010

1955 R. R. Avenue, 1010

1955 R. R. Avenue, 1010

1955 R. R. Avenue, 1010

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1955 R. R. Avenue, 1010

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04693

CERTIFICATE OF DEATH

04699

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 5628 Alhambra Ave.	
3. NAME OF DECEASED (Type or print) First Edward Middle J. Last Crogran		4. DATE OF DEATH Month April Day 3 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/16/85
9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 30 Days 4 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Printer		10b. KIND OF BUSINESS OR INDUSTRY Crown Cork & Seal	
11. BIRTHPLACE (County & State, or foreign country) Ireland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Crogran		14. MOTHER'S MAIDEN NAME Mary Neary	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-01-6766	
17. INFORMANT Daniel Crogran		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1992 IMMEDIATE CAUSE (a) Terminal Carcinomatosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cardiac Arrhythmia DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March 25, 1967 , to April 3, 1967 , that (I) (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 4:40 PM from causes and on the date stated above.			
22a. SIGNATURE Ramon P. Lopez		22b. DATE SIGNED April 3 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez		22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/6/1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR APR 4 1967	
4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

04880

04880

Name		Address	
Last Name		First Name	
Middle Name		Suffix	
City		State	
Zip		Country	
Telephone		Fax	
E-mail		Web	
Occupation		Education	
Marital Status		Date of Birth	
Date of Death		Cause of Death	
Burial Place		Crematorium	
Funeral Home		Cemetery	
Religion		Ethnicity	
Ancestry		Mileage	
Remarks		Comments	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1035 Ingleside Avenue		d. STREET ADDRESS 1035 Ingleside Avenue	
3. NAME OF DECEASED (Type or print) JOHN T. DALE		4. DATE OF DEATH Month April Day 8 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1900
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. BIRTHPLACE (County & State, or foreign country) Alabama		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William N. Dale		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 203-09-5818	
17. INFORMANT Mrs. Viola S. Dale		Address 1035 Ingleside Avenue	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding Esophageal Varices 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cardiac Cir. Losit of Liver DUE TO (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 1 week 5 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia due to Nephrosclerosis, arteriosclerotic, Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov. , 19 64 , to 4/8 , 19 67 ; that (I) (we) last saw the deceased alive on 4/8 19 67 , and that death occurred at 4 A M, from causes and on the date stated above.			
22a. SIGNATURE Dr. Max Miller		22b. DATE SIGNED 4/8/67	
22c. PHYSICIAN'S NAME (Type) Dr. Max Miller		22d. ADDRESS 1047 Ingleside Avenue	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-11-1967	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR APR 10 1967	
ADDRESS 4107 Wilkens Avenue		25b. REGISTRAR'S SIGNATURE John D. Judge	

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1001 Indiana Avenue

1001 Indiana Avenue

6-10-1967

June 10, 1967

1001 Indiana Avenue

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1001 Indiana Avenue

Dr. J. H. Miller

6-17-1967

1001 Indiana Avenue

1001 Indiana Avenue

1001 Indiana Avenue

1001 Indiana Avenue

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04701

CERTIFICATE OF DEATH

04701

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>305 Alabama Road</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u> d. STREET ADDRESS <u>510 Sudbrook Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Franklin</u> Middle <u>Davis</u> Last <u>Davis</u>				4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1967</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>April 5, 1890</u>		9. AGE (In years last birthday) <u>77</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - V. P.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Davis Construction</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Mitchellville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>Joseph Davis</u>				14. MOTHER'S MAIDEN NAME <u>Clara E. Parlett</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>216-03-4845</u>		17. INFORMANT Address <u>Mr. Joseph Davis 305 Alabama Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery Thrombosis</u> DUE TO (b) <u>Arteriosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Parkinson's Disease</u>								INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u> <u>unknown</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u>67</u> 20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>May 17, 1965</u> to <u>April 7, 1967</u> that (I) (we) last saw the deceased alive on <u>March 10, 1967</u> , and that death occurred at <u>7:30 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Martin E. Singewald</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>MARTIN E. SINGEWALD</u>		22d. ADDRESS <u>116 Chase St Baltimore</u>		22b. DATE SIGNED <u>4/7/67</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4/10/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harleigh Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Camden, New Jersey</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Dickman & Sons</u>				25a. REC'D BY REGISTRAR <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04702

04702

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN 1b 15 days			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTRE				e. STREET ADDRESS 5807 A WILLOWTON AVENUE			
3. NAME OF DECEASED (Type or print) JOSEPH G. DAVIS				4. DATE OF DEATH APRIL 23 1967			
5. SEX MALE		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/04/1897 69 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Verifier Mail Dept. Custom House				11. BIRTHPLACE (County & State, or foreign country) MONTCLARE, Pa.			
10b. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME WILLIAM DAVIS				14. MOTHER'S MAIDEN NAME KEPLINGER, Catherine			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, <input type="checkbox"/> No <input checked="" type="checkbox"/>) (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 216 097 053		17. INFORMANT PATIENT'S CHART Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma right lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-8 , 19 67 , to 4-23 , 19 67 , that (I) (we) last saw the deceased alive on 4-23 , 19 67 , and that death occurred at 9:25 AM , from the causes and on the date stated above.							
22a. SIGNATURE M. Beahle Mac Gregor				22b. DATE SIGNED 4-23-67			
22c. PHYSICIAN'S NAME (Type) E. HUNTER WILSON				22d. ADDRESS G.B.M.C. N. Charles St.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE f Charles Young	

MEDICAL CERTIFICATION

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04708

21214

Retired Verifier and Capt. Gordon House

Catharine

Continued right lung

X

Baltimore, Md.

Holy Redeemer Cemetery

Vol. 12

Page 1

Leonard J. Wood, no. 21214

APR 2 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
CERTIFICATE OF DEATH													
04703													
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Freeland</u>							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Freeland Rd.</u>						d. STREET ADDRESS <u>Freeland Rd.</u>							
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Loma</u> Middle <u>Viola</u> Last <u>Day</u>						4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1967</u>							
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 14, 1882</u>		9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>Abraham Krout</u>						14. MOTHER'S MAIDEN NAME <u>Ella Waltemeyer</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>						16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Greta Midwig, Freeland, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cardiovascular disease</u> 4221 DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u>years</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from <u>3-13, 1967</u> to <u>4-5, 1967</u> , that (I) (we) last saw the deceased alive on <u>3-24, 1967</u> , and that death occurred at <u>5:30 AM</u> , from the causes and on the date stated above.													
22a. SIGNATURE <u>Donald L. Bortner</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-6-67</u>					
22c. PHYSICIAN'S NAME (Type) <u>DONALD L. BORTNER</u>						22d. ADDRESS <u>NEW FREEDOM, PA.</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove E. U. B. Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Rayville, Md.</u>					
24. FUNERAL DIRECTOR <u>St. Jacob Hartenstein, New Freedom, Pa.</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					
DATE <u>APR 11 1967</u>													

04708

04708

Freeland Rd.
Rural - Freeland
Md.

Freeland Rd.
Rural - Freeland
Md.

Viola

Day

Jan. 14, 1882 82

Housewife
Krent

Balto Co, Md. U.S.A.
Ella Waltemeyer
Mrs. Greta Midwig, Freeland, Md.

No.

Rayville, Md.
Apr 11 1901
Pine Grove, E.B. Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> 04704 MARYLAND STATE DEPARTMENT OF HEALTH 04704 </div> <div style="text-align: center;"> DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <i>Balto. -</i>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Md. -</i> b. COUNTY <i>Balto. -</i>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural White Hall</i>				c. LENGTH OF STAY IN 1b <i>4 mo. -</i>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Rural - Freedland</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Vernon Rd. -</i>				d. STREET ADDRESS <i>Freedland Rd. -</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Welzetta</i> Middle <i>S.</i> Last <i>Day</i>				4. DATE OF DEATH Month <i>4</i> / Day <i>23</i> Year <i>1967</i>							
5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan 7, 1882</i>		9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during home life, even if retired) <i>home maker</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>own home. -</i>				11. BIRTHPLACE (County & State, or foreign country) <i>Balto. Md. - U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>A. E. Bahn. -</i>				14. MOTHER'S MAIDEN NAME <i>Carrie Smith. -</i>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>218-14-7750</i>				17. INFORMANT Address <i>Mrs. Pearce Harris White Hall, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>G. S. C. V disease</i> <i>4221</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>1950</i> to <i>Apr. 23, 1967</i> , that (I) (we) last saw the deceased alive on <i>Apr. 22</i> 19 <i>67</i> , and that death occurred at <i>5 P</i> M, from the causes and on the date stated above.											
22a. SIGNATURE <i>A. M. France</i>				22b. DATE SIGNED <i>4/23/67</i>							
22c. PHYSICIAN'S NAME (Type) <i>A. M. FRANCE M.D.</i>				22d. ADDRESS <i>Parkton, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>				23b. DATE THEREOF <i>April 26, 1967</i>		23c. NAME OF CEMETERY OR CREMATORY <i>West Liberty Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>White Hall, Md.</i>			
24. FUNERAL DIRECTOR <i>Jacob Hartenstein</i>				25a. REC'D BY REGISTRAR <i>Charles Judge</i>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			
				DATE <i>APR 27 1967</i>							

04504

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APR 21 1961
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

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FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04705

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04705

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, 7620 York Road, 21204				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3208 Echodale Avenue #21214 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First FRANK Middle GODFREY Last DEININGER				4. DATE OF DEATH Month April Day 5 Year 19 67																			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1-12-01		9. AGE (In years last birthday) yrs. 66		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maryland State Roads Commission				10b. KIND OF BUSINESS OR INDUSTRY Baltimore Md.				11. BIRTHPLACE (State or foreign country) Baltimore Md.				12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME John M. Deininger				14. MOTHER'S MAIDEN NAME Meta Kandler				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 216-09-1255				17. INFORMANT Mrs. Mabel E. Deininger Address (Same)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 612X DUE TO Cardiac Arrest During and After Surgery (b) For Transverse Section of Prostate DUE TO Severe Cardiac Vascular Arteriosclerosis (c) 10 yrs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												INTERVAL BETWEEN ONSET AND DEATH Sudden											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiac Heart Disease												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. No Cardiac Arrest due to Severe heart Damage				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.) Hospital				20f. (City or town) (County) (State) Towson #4 Balto Md.			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE Charles F. O'Donnell EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)				22. DATE SIGNED 4/5/67															
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/10/67.				23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City or Town) (County) (State) Baltimore, Md.											
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				ADDRESS				25a. REC'D BY REGISTRAR APR 7 1967				25b. REGISTRAR'S SIGNATURE Charles Judge											

04705

04705

1. The first part of the document is a letter from the
author to the editor of the journal. The letter is dated
1960 and is addressed to the editor of the journal.

2. The second part of the document is a letter from the
editor to the author. The letter is dated 1960 and is
addressed to the author.

3. The third part of the document is a letter from the
author to the editor. The letter is dated 1960 and is
addressed to the editor.

4. The fourth part of the document is a letter from the
editor to the author. The letter is dated 1960 and is
addressed to the author.

5. The fifth part of the document is a letter from the
author to the editor. The letter is dated 1960 and is
addressed to the editor.

6. The sixth part of the document is a letter from the
editor to the author. The letter is dated 1960 and is
addressed to the author.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04706

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04706

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere				c. LENGTH OF STAY IN b One Year			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 169 Ave. A, Rt. 10				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Josephine Middle Del Tergo Last Del Tergo				4. DATE OF DEATH Month April Day 21 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1889	9. AGE (In years last birthday) 78	IF UNDER 1 YEAR Months 03 Days 1	IF UNDER 24 HRS. Hours 1 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Sebastian Vincenti				14. MOTHER'S MAIDEN NAME Mary Anna Carco			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 011 14 0240		17. INFORMANT (Daughter) Mrs. Mary A. Loncala, 169 Ave. A. Rt. 10			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypo Thyroidism						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 9m 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theo C Patterson		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/21/67	
EXAMINER'S NAME (Type) THEO. C. PATTERSON		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county) 105 Main St. Dundalk, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/24/67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (City or Town) (County) (State) Malden, Mass.			
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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00700

THOMAS J. BROWN
JAN 19 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04707

CERTIFICATE OF DEATH

04707

1. PLACE OF DEATH o. COUNTY <u>Baltimore County</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. LENGTH OF STAY IN 1b <u>5 Months</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville 8, Md.</u> <u>13-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Robbs Nursing Home</u>			d. STREET ADDRESS <u>309 Church Lane</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <u>Josefa Maria Devilbiss</u> First Middle Last			4. DATE OF DEATH <u>April 8,</u> 19 <u>67</u> Month Day Year		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 25, 1884</u>	9. AGE (In years lost birthday) yrs. <u>82</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>Frederick Hulshof</u>			14. MOTHER'S MAIDEN NAME <u>Mueller</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>214-16-8958d</u>	17. INFORMANT Address <u>Md.</u> <u>Mrs. Dorothy Grimm, 309 Church Lane, Pikesville</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of lt breast with metastases</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>7 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic heart disease</u>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> , 19 <u>62</u> , to <u>Apr 8</u> , 19 <u>67</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>Apr 5</u> 19 <u>67</u> , and that death occurred at <u>39</u> M, from <u>causes</u> and on the date stated above.					
22a. SIGNATURE <u>Paul H Royse</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Apr 10, 1967</u>
22c. PHYSICIAN'S NAME (Type) <u>Paul H Royse</u>			22d. ADDRESS <u>1403 Foley Lane, Pikesville, Md</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Bethel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>New Windsor, Md.</u>		
24. FUNERAL DIRECTOR <u>Frank H. Stenell, Pikesville 8, Md</u>			25a. REC'D BY REGISTRAR <u>APR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

04703

04703

CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
HONORARY MEDICAL OFFICER
HONORARY MEDICAL OFFICER

1. Name of Deceased

2. Sex

3. Age

4. Date of Birth

5. Date of Death

6. Place of Death

7. Cause of Death

8. Manner of Death

9. Signature of Medical Officer

10. Signature of Registrar

11. Date of Entry

12. Signature of Registrar

13. Date of Entry

14. Signature of Registrar

15. Signature of Registrar

16. Signature of Registrar

17. Signature of Registrar

18. Signature of Registrar

19. Signature of Registrar

20. Signature of Registrar

21. Signature of Registrar

22. Signature of Registrar

23. Signature of Registrar

24. Signature of Registrar

25. Signature of Registrar

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04708

CERTIFICATE OF DEATH

04708

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House In the Pines 16 Fusting Ave.		d. STREET ADDRESS 4401 Flowerton Rd.	
3. NAME OF DECEASED (Type or print) Daisy Dittell		4. DATE OF DEATH April 28, 1967	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 7, 1875
9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME John Thompson		14. MOTHER'S MAIDEN NAME Mary Hush	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Stanley Magersupp		Address #21093 2315 Ravenview Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Hypostatic Pneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardio-Vascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 days 12 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fractured Left Hip 6/12/66		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/4 , 19 54 , to 4/28 , 19 67 that (I) (we) last saw the deceased alive on 4/27 , 19 67 , and that death occurred at 3:51 P.M. from causes and on the date stated above.			
22a. SIGNATURE Edw. W. Johnson		22b. DATE SIGNED 4/29/67	
22c. PHYSICIAN'S NAME (Type) Dr. E.W. Johnson		22d. ADDRESS 3437 Frederick Ave Baltimore Md 21229	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5-1-1967	23c. NAME OF CEMETERY OR CREMATORY Western	23d. LOCATION (City or Town) (County) (State) Balto. Maryland
24. FUNERAL DIRECTOR Witzke & Sons 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR MAY 1 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04703		CERTIFICATE OF DEATH				04709			
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212 21212				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital					d. STREET ADDRESS 1029 Upnor Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harold Middle H. Last Duckworth Sr.					4. DATE OF DEATH Month April Day 11 Year 1967				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-12		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS. Hours 10 Min. 67	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Small Loan Examiner - State of Maryland			10b. KIND OF BUSINESS OR INDUSTRY Lonaconing, Md.		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edward Duckworth					14. MOTHER'S MAIDEN NAME Agnes Holmes				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 165-03-2948		17. INFORMANT Mrs. Gilverta M. Duckworth (Same)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive gastro-intestinal hemorrhage DUE TO (b) hemorrhagic hypertrophic gastritis. (c) Post-operative Exploratory Laparotomy pseudo-cyst of pancreas.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that 4 (this hospital) attended the deceased from March 29, 1967 to April 11, 1967 , that 0 (we) last saw the deceased alive on April 11, 1967 , and that death occurred at 6:05 AM , from causes and on the date stated above.									
22a. SIGNATURE Lawrence F. Misanik, M.D.					22b. DATE SIGNED April 11, 1967		22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment					23b. DATE THEREOF 4/14/1967		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.					25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04710

CERTIFICATE OF DEATH

04710

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3521 MILLVALE ROAD		d. STREET ADDRESS 3521 MILLVALE ROAD	
3. NAME OF DECEASED (Type or print) HARRY EDELBURG		4. DATE OF DEATH APRIL 21, 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE		10b. KIND OF BUSINESS OR INDUSTRY REPAIR	11. BIRTHPLACE (County & State, or foreign country) POLAND
13. FATHER'S NAME ISAAC EDELBURG		14. MOTHER'S MAIDEN NAME SARAH ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN	
17. INFORMANT MRS. ANNA EDELBURG		Address 3521 MILLVALE ROAD #7	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis C.V.D. DUE TO (c) 1132?			INTERVAL BETWEEN ONSET AND DEATH 4 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July, 1957 to 21 April, 1967 that (I) (we) last saw the deceased alive on 21 April 1967 , and that death occurred at 7:10 P.M. from causes and on the date stated above.			
22a. SIGNATURE DR. JOSEPH GROSS		22b. DATE SIGNED 4-21-67	
22c. PHYSICIAN'S NAME (Type) DR. JOSEPH GROSS		22d. ADDRESS 6911 PARK HEIGHTS AVENUE	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4/23/67	23c. NAME OF CEMETERY OR CREMATORY HEBREW YOUNG MEN	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.		25a. REC'D BY REGISTRAR APR 25 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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OFFICE OF THE

UNITED STATES DEPARTMENT OF AGRICULTURE
WASHINGTON, D. C. 20250

MEMORANDUM

ATTENTION

DATE

RE: MEMORANDUM

RE: MEMORANDUM

APRIL 11, 1954

RE: MEMORANDUM

RE: MEMORANDUM

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04711

CERTIFICATE OF DEATH

04711

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore (Dundalk)			c. LENGTH OF STAY IN 1b 20 yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Dundalk			d. STREET ADDRESS 1818 Tyler Rd	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore City Hospital 59 Dundalk Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Florence Middle Edwards Last				4. DATE OF DEATH Month 4 Day 25 Year 1967				
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5-31-1921		9. AGE (In years lost birthday) 45 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (County & State, or foreign country) Wireton W, Va		12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Anthony Szczech				14. MOTHER'S MAIDEN NAME Mary Puskwicz				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes give war or dates of service) 212416-4442		17. INFORMANT Address Hubert Edwards 1818 Tyler Rd				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Jan 9, 1967 , to April 25, 1967 that (I) (we) lost the deceased alive on April 25, 1967 , and that death occurred at 7:00 p.m. from causes and on the date stated above.								
22a. SIGNATURE Benigno R. Lazaro				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) BENIGNO R. LAZARO				22d. ADDRESS 59 Dundalk Ave. Balt. Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-29-67	23c. NAME OF CEMETERY OR CREMATORY Sacred Heart of Mary		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Walter Dabrowski 1005 Dundalk Avenue				25a. REC'D BY REGISTRAR MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Robert Edwards, 1915, Jan 14

Anthony, 1915, Jan 14

William, 1915, Jan 14

John, 1915, Jan 14

George, 1915, Jan 14

John, 1915, Jan 14

George, 1915, Jan 14

William, 1915, Jan 14

John, 1915, Jan 14

John, 1915, Jan 14

William, 1915, Jan 14

John, 1915, Jan 14

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04712

CERTIFICATE OF DEATH

04712

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>years</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Towson Convalescent Home</u>		d. STREET ADDRESS <u>520 Morris Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>EVAN</u> Middle <u>R.</u> Last <u>ELLIOTT</u>		4. DATE OF DEATH Month <u>Apr.</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 8, 1881</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>John W. Shepperd</u>		14. MOTHER'S MAIDEN NAME <u>Ida Bacon</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-466611</u>	
17. INFORMANT <u>Virginia Einstein</u>		Address <u>4504 Manders Rd Balto. 29</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>A.S.C.V. disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u>46</u> , to <u>4/8</u> , 19 <u>67</u> , that (I) <u>we</u> lost saw the deceased alive on <u>3/27</u> , 19 <u>67</u> , and that death occurred at <u>2:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>G. M. France</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>		22d. ADDRESS <u>PARKTON, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Apr. 11, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. James Methodist Church</u>	23d. LOCATION (City or town) (County) (State) <u>Balto. Co. Md.</u>
24. FUNERAL DIRECTOR <u>Mr. Cook, Brooks Towson</u>		25a. REC'D. BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 12 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>04713</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>04713</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural-White Hall</u>						c. LENGTH OF STAY IN 1b <u>4 yrs.</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Wiseburg Rd.</u>						d. STREET ADDRESS <u>Wiseburg Rd.</u>					
3. NAME OF DECEASED (Type or print) <u>Clyde M. Ensom</u>						4. DATE OF DEATH <u>APR 2</u> 1967					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 4, 1911</u>		9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Trucker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Truckings</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Sparks, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Alex Ensom</u>						14. MOTHER'S MAIDEN NAME <u>Hester Mays</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>				16. SOCIAL SECURITY NO. <u>212-03-5298</u>		17. INFORMANT <u>Melva F. Ensom, White Hall, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hodgkins Disease</u> <u>201X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>65</u> , to <u>APR 2</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>APR 1</u> , 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>A. M. France</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>APR 2</u>			
22c. PHYSICIAN'S NAME (Type) <u>A. M. FRANCE</u>						22d. ADDRESS <u>YAKK TON, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)					
<u>Burial</u>		<u>April 5, 1967</u>		<u>Black Rock Cemetery</u>		<u>Butler, Md.</u>					
24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>g. Charles Judge</u>			

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29th May 1961

Western May 2

212-03286 Melrose, Frank, 1911

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04714

CERTIFICATE OF DEATH

04714

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills			c. LENGTH OF STAY IN 1b 2 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bladenburg		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital				d. STREET ADDRESS 202 McLain Ave.,		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cheryl Denise ETHERIDGE		First Middle Last		4. DATE OF DEATH Month 4 Day 5 Year 19 67			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/64		9. AGE (In years last birthday) 2 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (County & State, or foreign country) Bladenburg, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Leroy Ethridge			14. MOTHER'S MAIDEN NAME Hazel Nichols				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. ----		17. INFORMANT Address Rosewood Records Owings Mills, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) CONGENITAL HYDROCEPHALUS DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH LIFE	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that 18 (this hospital) attended the deceased from Dec. 30, 1964 , to Apr. 5, 1967 , that 18 (we) last saw the deceased alive on April 5, 1967 , and that death occurred at 9:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE Joyce M. Boyd			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-6-67		
22c. PHYSICIAN'S NAME (Type) Joyce M. Boyd, M.D.			22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Rosewood Cemetery		23d. LOCATION (City or Town) (County) (State) Owings Mills, Md.			
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR APR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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04714

STATEMENT OF DEATH

04714

Form with multiple lines for text entry, including fields for name, date, and other details. The text is faint and mostly illegible due to the quality of the scan. Some visible text includes "STATEMENT OF DEATH" and "04714".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04715

CERTIFICATE OF DEATH

04715

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY IN 1b 9 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 17 Alston Rd.				d. STREET ADDRESS 17 Alston Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First David Middle Brinley Last Evans				4. DATE OF DEATH Month April Day 21 Year 19 67					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 2, 1889			
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months 77 Days 77 Hours 77 Min. 77		IF UNDER 24 HRS. Months 77 Days 77 Hours 77 Min. 77					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Order Clerk			10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (County & State, or foreign country) Wales		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Thomas Evans				14. MOTHER'S MAIDEN NAME Anne Daniels					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 213-07-7993		17. INFORMANT Miss Lillian M. Evans			Address 17 Alston Rd. 21093	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest due to myocardial infarction due 1201 DUE TO to arteriosclerotic cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20 years							INTERVAL BETWEEN ONSET AND DEATH 2 years		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED: (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work or work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (1) (this hospital) attended the deceased from April , 1965, to April 19 , 1967, that (1) (we) last saw the deceased alive on April 19 , 1967, and that death occurred at 8:50p M, from causes and on the date stated above.									
22a. SIGNATURE Donald O. Wood				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-22-67			
22c. PHYSICIAN'S NAME (Type) DONALD O. WOOD, M.D.				22d. ADDRESS York Road and Greenmeadow Dr. Timonium, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/25/67		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.			
24. FUNERAL DIRECTOR Wm. Cook-Brooks				ADDRESS Towson 1050 York Rd. 21204		25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH Item #2c & d Film #G388 5/8/67 pg											
04716 1. PLACE OF DEATH e. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Presbyterian Home				04716 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson/ Balto. d. STREET ADDRESS 2306 Denmore Ave. Dixie Drive e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Pauline Middle Lena Last FALLON				4. DATE OF DEATH Month Apr Day 29 Year 1967							
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 15, 1876		9. AGE (In years last birthday) 91 yrs.		10. IF UNDER 1 YEAR Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Waydeline						14. MOTHER'S MAIDEN NAME Catherine Glek					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO.		17. INFORMANT Address Presbyterian Home of Md. Towson, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from JAN 1958 to APRIL 29, 1967 , that (I) (we) last saw the deceased alive on APRIL 26 1967 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE S. J. VENABLE, JR MD						22b. DATE SIGNED 7/24/1967					
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS 7215 YORK RD BALTIMORE MD					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 5/2/67		23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24 FUNERAL DIRECTOR'S SIGNATURE Mitchell-Wiedefeld Home						ADDRESS 6500 York Rd. Balto., Md. 21212		25a. REC'D BY REGISTRAR DATE MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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STATE OF OHIO

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
04717 1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				04717 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY BALTO							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODLAWN				c. LENGTH OF STAY IN 1b WOODLAWN 03-1				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WOODLAWN			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Box-190 - Dogwood Rd.				d. STREET ADDRESS Box-190 - Dogwood Rd.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) THOMAS DAVIS FANTOM				4. DATE OF DEATH APRIL 20 1967							
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOV 2, 1899		9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months Oays Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CONTRACTOR SELF				10b. KIND OF BUSINESS OR INDUSTRY BUILDING		11. BIRTHPLACE (County & State, or foreign country) MD.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME JOHN H.				14. MOTHER'S MAIDEN NAME EMMALINE MCGEE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. W.W.I		17. INFORMANT Ms. Alice Fantom - Dogwood Rd. #7		Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion H&OI DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General Arteriosclerosis DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 1 day ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 64 to April , 19 67 , that (I) (we) last saw the deceased alive on April 19 67 , and that death occurred at 4 P M, from the causes and on the date stated above.											
22a. SIGNATURE Roman Palagia				ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4/21/67			
22c. PHYSICIAN'S NAME (Type) Roman Palagia				22d. ADDRESS 3336 Funderburk Balto 29 Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Cem.		23d. LOCATION (City, town or county) (State) Balto. Md.					
24. FUNERAL DIRECTOR Foley, Corrado & Co. Catonsville, Md.				ADDRESS				25a. REC'D BY REGISTRAR APR 28 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Ernestine Schenck
St. Louis, Mo.

James M. Cooper
April 21
you 48 years
338 Jackson St. St. Louis

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G3871/19/67 ps

04718

CERTIFICATE OF DEATH

04718

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. LENGTH OF STAY IN 1b 8 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2209 Wilker avenue				d. STREET ADDRESS 2209 Wilker avenue			
3. NAME OF DECEASED (Type or print) DORIS MAY FENWICK				4. DATE OF DEATH April 13 1967			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1921 Nov 1, 1921	
9. AGE (In years last birthday) 45 yrs		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home				10b. KIND OF BUSINESS OR INDUSTRY Housewife		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Harry Lewis				14. MOTHER'S MAIDEN NAME Marie A. Emmart			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Family Records	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Carcinomatous 1930 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cystic glioma DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) dehydration, Cerebral hematoma						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan , 19 58 , to Apr , 19 67 , that (II) (we) last saw the deceased alive on Apr , 19 67 , and that death occurred at 8:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE Frank J. Kasik				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/15/67	
22c. PHYSICIAN'S NAME (Type) FRANK J. KASIK JR MD				22d. ADDRESS 9005 Harford road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION (City or Town) (County) (State) Parkville, balto. Md.	
24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road				25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04719

CERTIFICATE OF DEATH

04719

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore, Md. 2204				d. STREET ADDRESS 6116 Sefton Avenue 21214			
3. NAME OF DECEASED (Type or print) First Middle Last AGNES FERRUGGIO				4. DATE OF DEATH Month Day Year April 16 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-25-04	
9. AGE (In years last birthday) 63-62 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME William McDonough			
14. MOTHER'S MAIDEN NAME Nora ?				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no			
16. SOCIAL SECURITY NO.				17. INFORMANT Husband Pietro Ferruggio Address Same as patient			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260X Diabetic Coma DUE TO (b) Cerebral vascular hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic hypertensive heart disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-3-67 , 19 67 , to 4-16 , 19 67 that (I) (we) last saw the deceased alive on 4-16- 19 67 , and that death occurred at 10P M, from causes and on the date stated above.							
22a. SIGNATURE E. Reyes				22b. DATE SIGNED 4-16-67		22c. PHYSICIAN'S NAME (Type) E. Reyes, M.D.	
22d. ADDRESS 7620 York Road, Baltimore, Maryland 21204				22e. REGISTRAR'S SIGNATURE Charles Judge			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/67		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, inc. 5305 Harford Rd.				25a. REC'D BY REGISTRAR DATE APR 17 1967			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04720

04720

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)			c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Essex (21)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1023 Eastern Avenue				d. STREET ADDRESS 1023 Eastern Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last DANIEL LINDERMAN FINCH				4. DATE OF DEATH Month Day Year April 11, 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 20, 1903		9. AGE (In years last birthday) 64 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Proctor-Gamble Co.		11. BIRTHPLACE (County & State, or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Finch				14. MOTHER'S MAIDEN NAME Lillian Linderman			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 218 01 2228		17. INFORMANT Address Margaret Finch Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis. DUE TO (c) Diabetes mellitus.						INTERVAL BETWEEN ONSET AND DEATH None	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-6 , 19 66 , to 4-10 , 19 67 that (I) (we) last saw the deceased alive on 4-10 , 19 67 , and that death occurred at 2:30 P.M. from causes and on the date stated above.							
22a. SIGNATURE Leopoldo Gruss M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-11-67	
22c. PHYSICIAN'S NAME (Type) Leopoldo Gruss, M.D.				22d. ADDRESS 405 Stemmers Run Rd. Balto., Md. 21221			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Bruzdzinski ADDRESS 1407 Eastern Ave.				25a. REC'D BY REGISTRAR DATE APR 13 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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sex (SI)

sex (SI)

1003 Eastern Avenue

1003 Eastern Avenue

Jan. 20, 1903

White

Proctor-Corbin Co.

Proctor-Corbin Co.

William L. Latham

Joseph Finch

James C. Finch

218 St 2228

Unknown

405 Stephens Ave. N.E., Wash., D.C.

Isabelle Grass, N.E.

William L. Latham

Proctor-Corbin Co.

White

Proctor-Corbin Co.

Isabelle Grass, N.E.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04721

CERTIFICATE OF DEATH

04721

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> COUNTY <u>Baltimore</u> <u>6614 Chelwood Road</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. LENGTH OF STAY IN 1b <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>6614 Chelwood Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Beverlee ANN Finkelstein</u>		4. DATE OF DEATH <u>April 27 1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-28-23</u>
9. AGE (In years last birthday) <u>43</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MITCHELL SOUTH DAKOTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Itai fetz</u> XXXXXXXXXXXX <u>ABRAHAM</u>		14. MOTHER'S MAIDEN NAME XXXXXXXXXXXX <u>Hattie S. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>MR. JONAH B. FINKELSTEIN, 6614 CHELWOOD RD.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>103X</u> DUE TO <u>Terminal Ca of the lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>with diffuse metastasis</u> (c) <u>with diffuse metastasis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-20</u> , 19 <u>67</u> , to <u>4-27</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-27</u> , 19 <u>67</u> , and that death occurred at <u>1:50 PM</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Diadema Simon, M.D.</u>		22b. DATE SIGNED <u>4-27-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DRADEMA SIMON</u>		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/30/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>SHALOM MEMORIAL PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>ILLINOIS</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04351

CERTIFICATE OF DEATH

04351

04351

CERTIFICATE OF DEATH

04722

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Balt. 21207	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balt. County General Hospital		d. STREET ADDRESS 8400 Merrymount Drive	
3. NAME OF DECEASED (Type or print) First HENRY Middle L. Last FINNISEY		4. DATE OF DEATH Month 4 Day 27 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-9-01
9. AGE (In years last birthday) 65 yrs		10. IF UNDER 1 YEAR Months 6 Days 1 Hours 1 Min. 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY IC	
11. BIRTHPLACE (County & State, or foreign country) Pa. Philadelphia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George A. Finnisey		14. MOTHER'S MAIDEN NAME Baker, Catherine	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 21207	
17. INFORMANT Mr. Lee R. Finnesey-8400 Merrymount Dr.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subdural hemorrhage DUE TO 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 4-26, 1967 to 4-27, 1967 that (I) (we) last saw the deceased alive on 4-27, 1967 , and that death occurred at 10:20 P.M. from causes and on the date stated above.			
22a. SIGNATURE Antonio R. Jara		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) ANTONIO R. JARA		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/67	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) 6 E. Franklin St. Balt. 21202	
24. FUNERAL DIRECTOR Loring Byers-8728 Liberty Rd. Randallstown		25a. REC'D BY REGISTRAR MAY 1 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04728

THE STATE OF CALIFORNIA

04728

Date: 11/10/71

County: Mendocino

8400 Highway Drive

Half, County General Hospital

Mendocino

California

11/10/71

Dr. Lee E. Flannery-8400 Highway Dr.

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Dr. Lee E. Flannery-8400 Highway Dr.

11/10/71

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11/10/71

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

(M)

(1)

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>_____</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TOWSON</u>		c. LENGTH OF STAY IN lb <u>1 DAY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		<u>2 12 30</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>STELLA MARIS HOSPICE</u>				d. STREET ADDRESS <u>1508 COVINGTON ST.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM EDWARD FISCHER</u>				4. DATE OF DEATH Month Day Year <u>APR. 10, 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 20, 1912</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STEAMBOAT ENGINEER BOILERS INSTITUTION</u>		11. BIRTHPLACE (State or foreign country) <u>ELKTON, MD., Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN FREDERICK FISCHER</u>				14. MOTHER'S MAIDEN NAME <u>EDITH ESTELLE WOOTEN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>218-97-7075</u>		17. INFORMANT <u>HENRY J. FISCHER (DPO) - Same</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X Coronary Occlusion</u> DUE TO (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>Diabetes Mellitus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>2 + 1/2</u> <u>5 + yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE <u>Charles F. O'Donnell</u>		23. EXAMINER'S NAME (Type) <u>CHARLES F. O'DONNELL, M.D.</u>		24. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		25. DATE SIGNED <u>4/10/67</u>	
26. ADDRESS <u>1400S. CHARLES ST</u>		27. CITY OR TOWN <u>BALTO, MD</u>		28. STATE <u>MD</u>		29. ZIP CODE <u>21230</u>	
30. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		31. DATE THEREOF <u>APR 13 1967</u>		32. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet</u>		33. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD</u>	
34. FUNERAL DIRECTOR <u>Curtis E. Evans</u>		35. ADDRESS <u>1400S. CHARLES ST</u>		36. CITY OR TOWN <u>BALTO, MD</u>		37. STATE <u>MD</u>	
38. ZIP CODE <u>21230</u>		39. REC'D BY REGISTRAR <u>HRK 11 1967</u>		40. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
 Item #9 Film #G387 4/11/67 pc

04724

CERTIFICATE OF DEATH

04724

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE c. LENGTH OF STAY IN b LIFE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PARKVILLE d. STREET ADDRESS 3207 E. Joppa road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) REID S. FISHPAW First Middle Last		4. DATE OF DEATH April 11 19 67 Month Day Year	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 7 1913 9. AGE (In years last birthday) 53 5/4 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FOREMAN		10b. KIND OF BUSINESS OR INDUSTRY BALTO CO WATER	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME GUR R. FISHPAW	
14. MOTHER'S MAIDEN NAME HILDA TRACEY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW 2	
16. SOCIAL SECURITY NO. 218-09-2241		17. INFORMANT FAMILY RECORDS Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial degeneration Stokes Adams 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) with Coronary artery Disease INTERVAL BETWEEN ONSET AND DEATH 1-24			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from June 1966 , to April 1967 , that (I) (we) last saw the deceased alive on April 4 1967 , and that death occurred at 11 A M , from causes and on the date stated above.			
22a. SIGNATURE Frank Kasik		22b. DATE SIGNED 4/12/67	22c. PHYSICIAN'S NAME (Type) FRANK KASIK M.D.
22d. ADDRESS 9005 Harford road		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE THEREOF 4/14/67		23c. NAME OF CEMETERY OR CREMATORY BALTO NAT CEM	
23d. LOCATION (City or Town) (County) (State) Baltimore, Md.		24. FUNERAL DIRECTOR C.F. EVANS & SON 8802 Harford road ADDRESS	
25a. REC'D BY REGISTRAR APR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04725

CERTIFICATE OF DEATH

04725

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Balto. City c. LENGTH OF STAY IN 1b 1 da d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 3626 Sylvan Drive Balto 7, Md		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Rhode Island b. COUNTY Chepachet c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 76-3 d. STREET ADDRESS Oil Mill Lane e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Mary Middle Gladys Last Flynn		4. DATE OF DEATH Month April Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 6, 1900
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Blackstone, Massachusetts		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Chapman		14. MOTHER'S MAIDEN NAME Mary Tierney Daniels	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 038-16-0445	
17. INFORMANT Mr. John Torpey		Address 3626 Sylvan Dr. Balto 7, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) acute coronary occlusion 260X DUE TO ASHD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) diabetes mellitus DUE TO (c) diabetes mellitus			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4/8/67 , 19__, to 4/8/67 , 19__, that (I) (we) lost the deceased alive on 4/8/67 , 19__, and that death occurred at 4:30 M. from causes and on the date stated above.			
22a. SIGNATURE Milton Schlenoff		22b. DATE SIGNED 4/8/67	
22c. PHYSICIAN'S NAME (Type) Milton Schlenoff		22d. ADDRESS 6410 Windsor Mill Rd	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/11/67	23c. NAME OF CEMETERY OR CREMATORY St Patrick	23d. LOCATION (City or Town) (County) (State) Pascoag Rhode Isl.
24. FUNERAL DIRECTOR Spring Myers		25. REC'D BY REGISTRAR APR 11 1967	
26. ADDRESS 8728 Liberty Rd		27. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove棺盖 papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04726

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04726

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas			c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Texas		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 9932 1926 Ellengowan Road				d. STREET ADDRESS 9932 1926 Ellengowan Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ANNA Middle MAY Last FORD				4. DATE OF DEATH Month April Day 13 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 24, 1918		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory Work		10b. KIND OF BUSINESS OR INDUSTRY ASSEM		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Homer Gover				14. MOTHER'S MAIDEN NAME Nellie May Free			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. ???		17. INFORMANT Address Mr. James E. Ford, Sr., Same as # 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED April 14, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 17, 1967		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1059 York Road Towson, Md. 21204				25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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APR 11 1967

Charles Judge

VR A15 (4)
20M 5-63

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (and) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04728

04728

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 3016 Northern Parkway	
3. NAME OF DECEASED (Type or print) First Middle Last Margaret A. Fox		4. DATE OF DEATH Month Day Year April 23, 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-17-91
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Sebastian Miller		14. MOTHER'S MAIDEN NAME Margaret Ferncase	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Robert Deppisch, 3024 Fleetwood Ave.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of right breast with widespread metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 16, 1967 to April 23, 1967 , that (I) (we) last saw the deceased alive on April 23, 19 67 and that death occurred at 11:50 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Jaime Ambrad</i> M.D.		22b. DATE SIGNED April 23, 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad M.D.		22d. ADDRESS 7620 York Road - Towson 21204, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/27/67.	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR APR 27 1967	
25b. REGISTRAR'S SIGNATURE <i>J. C. ...</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04729

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 2110 Triandos Drive	
3. NAME OF DECEASED (Type or print) First Middle Last EVA Ness FRANTZ		4. DATE OF DEATH Month Day Year 4 18 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/10/1901
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Organist - Episcopal Church		11. BIRTHPLACE (State or foreign country) Balto., Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME William Ness	
14. MOTHER'S MAIDEN NAME Claudia Vaughn		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Address Luther M. Frantz 2110 Triandos Drive	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterioscleretic Cardiovascular disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE RUSSELL S. FISHER, M.D.		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 4-19-67			
23a. BURIAL, CREMATION, or other disposal (Specify)	23b. DATE THEREOF 4/21/67	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City or Town) (County) (State) Balto. County, Md.
24. FUNERAL DIRECTOR ADDRESS Mitchell-Wiedefeld Home 6500 York Rd. Balto., Md. 21212		25a. REC'D BY REGISTRAR APR 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge

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04730

VR A15 (4)
25M 1/67

1. PLACE OF DEATH a. COUNTY BALTIMORE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 67 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 231 N. GILMORE STREET	
3. NAME OF DECEASED (Type or print) JOSEPHUS DAMEL FRYAR		4. DATE OF DEATH Month APRIL Day 1 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 13, 1916
9. AGE (In years lost birthday) 51 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	
11. BIRTHPLACE (County & State, or foreign country) MC LEANSVILLE, N. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JULIUS FRYAR		14. MOTHER'S MAIDEN NAME SARAH MATIER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 217 18 17 84	
17. INFORMANT VA HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY INFARCTION, RIGHT UPPER LOBE DUE TO (b) PNEUMONIA, UNDETERMINED ORGANISM, RIGHT UPPER LOBE DUE TO (c) DIABETES MELLITUS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 1 WEEK	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from JAN. 24, 1967 , to APRIL 1, 1967 , that (A) (we) last saw the deceased alive on APRIL 1, 1967 , and that death occurred at 250AM , from causes and on the date stated above.			
22a. SIGNATURE <i>Neilon Neilson</i>		22b. DATE SIGNED 4/3/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-5-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Morten & Dyett Funeral Home		25a. REC'D BY REGISTRAR DATE APR 5, 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04731

CERTIFICATE OF DEATH

04731

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 9 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GRIER Middle G. Last FULLERTON		4. DATE OF DEATH Month APRIL Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/15/01
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		9b. AGE (In years last birthday) yrs. 66	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unk.		14. MOTHER'S MAIDEN NAME unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 209 03 74 38	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) SUB DURAL HEMORRHAGE DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 4/7/67 , 19__, to 4/16/67 , 19__, that we last saw the deceased alive on 4/16/67 , 19__, and that death occurred at 3:25AM , from causes and on the date stated above.			
22a. SIGNATURE Raul de Castro		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) RAUL DE CASTRO, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/19/67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Joseph N. Zannino		25a. REC'D BY REGISTRAR APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. ADDRESS 257 S. Conkling St. Baltimore, Md.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04732

CERTIFICATE OF DEATH

04732

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Halethorpe			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1604 Claridge Ave. 21227				d. STREET ADDRESS 1604 Claridge Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William First J. Middle Gallagher Last				4. DATE OF DEATH Month April Day 24 Year 67			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4/13/95	
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Inspector	
10b. KIND OF BUSINESS OR INDUSTRY B C H D				11. BIRTHPLACE (County & State, or foreign country) Illinois		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Gallagher				14. MOTHER'S MAIDEN NAME Mame MacNinny			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-18-9934		17. INFORMANT Address Mrs. Loretta M. Gallagher 1604 Claridge Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastro - Intestinal Hemorrhage 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of the Esophagus DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH minutes months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1965, to 4/24, 1967, that (I) (we) last saw the deceased alive on Dec 1966, and that death occurred at 2:30 AM, from causes and on the date stated above.							
22a. SIGNATURE James J. Nolan				22b. DATE SIGNED 4/24/67		22c. PHYSICIAN'S NAME (Type) James J. Nolan	
22d. ADDRESS 416 Kensington Ave.				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS 416 Kensington Ave.	
23a. BURIAL, CREMATION, or other disposal (Specify) Burial		23b. DATE THEREOF 4/27/67		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard				25a. REC'D BY REGISTRAR 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove and retain pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04733

STATEMENT OF FACTS

04733

State of New York

County of New York

In and for the County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

City of New York

State of New York

County of New York

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State of New York

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County of New York

City of New York

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04733

04733

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Lutherville 21093		Lutherville 21093	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 34 E. Seminary Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Susie Middle Gambrill Last Gambrill		4. DATE OF DEATH Month April Day 8 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-4-75
9. AGE (In years last birthday) 92 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Asa Alban		14. MOTHER'S MAIDEN NAME Elizabeth Hoffman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Family Records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary thrombo embolism. 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary edema		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that NO (this hospital) attended the deceased from March 26 , 1967 to April 8 , 1967, that NO (we) last saw the deceased alive on April 8 , 1967, and that death occurred at 12:40 M from causes and on the date stated above.			
22a. SIGNATURE Reynaldo Orjuela-Gomez, M.D.		22b. DATE SIGNED April 8, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Apr. 10, 1967	
23c. NAME OF CEMETERY OR CREMATORY Gunpowder Baptist Cem.		23d. LOCATION (City or Town) (County) (State) Exlo, Balto. Co., Md.	
24. FUNERAL DIRECTOR John Burns' Sons, Towson, Md.		25a. REC'D BY REGISTRAR APR 12 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05733

05733

RECEIVED

APR 12 1984

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
04734 1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12 c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Armacost Nursing Home					04734 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore 12 c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore 12 d. STREET ADDRESS 1410 Kingsway Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) Catherine Virginia Gannon First Middle Last			4. DATE OF DEATH April 27 1967 Month Day Year		5. SEX F 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/16-1876 9. AGE (In years last birthday) 90 yrs. IF FUNOER 1 YEAR Months Days IF FUNOER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Harris					14. MOTHER'S MAIDEN NAME Sarah				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Laurence Sullivan Address 1410 Kingsway Rd				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC BRAIN SYNDROME. (c) ARTERIOSCLEROSIS GENERALIZED								INTERVAL BETWEEN ONSET AND DEATH 4 DAYS. 5 YEARS+ 10 YEARS+	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from MARCH 1967 to APRIL 27, 1967 , that (I) (we) last saw the deceased alive on APRIL 27 1967 , and that death occurred at 232M , from the causes and on the date stated above.									
22a. SIGNATURE Arthur Karfgin					22b. DATE SIGNED 4/28/67		22c. PHYSICIAN'S NAME (Type) Arthur Karfgin		
22d. ADDRESS 1532 Havenwood Road									
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 4/29/67		23c. NAME OF CEMETERY OR CREMATORY Greenmount Mausoleum		23d. LOCATION (City, town or county) (State) Baltimore, Md.			
24. FUNERAL DIRECTOR Henry W. Jenkins & Sons Co ADDRESS 4905 York Road, Baltimore, Md. 21212					25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE [Signature]		

01734

CERTIFICATE OF DEATH

01734

Lawyer

Lawyer

Witness

Witness

1110 Highway Road

1110 Highway Road

27-28

April

1967

Virginia

Catholics

20

2/20-2/25

2

White

2

1967

Baltimore, Md

John Home

Home

John

John

Mrs. Lawrence Sullivan

John

20

1110 Highway Road

1110 Highway Road

1110 Highway Road, Baltimore, Md.

1110 Highway Road, Baltimore, Md.

1110 Highway Road, Baltimore, Md. 1110 Highway Road, Baltimore, Md. 1110 Highway Road, Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
04735 CERTIFICATE OF DEATH 04735													
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Randallstown</u> c. LENGTH OF STAY IN 1b <u>2 weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Chapel Hill Nursing - Randallstown, Md.</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore, 21207 Maryland</u> d. STREET ADDRESS <u>8409 Maryland Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Emil J (GAWEL) Gawel</u>			4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1967</u>			5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Rockwell Island</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Machinist</u>			9. AGE (In years last birthday) <u>89</u> yrs.			11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>				
13. FATHER'S NAME <u>Matthias Gawel</u>						12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>						14. MOTHER'S MAIDEN NAME <u>Hermania</u>			17. INFORMANT <u>MRS MARY BRANFORD</u> Address <u>8409 Maryland Drive Baltimore, Md 21209 M.N.</u>				
16. SOCIAL SECURITY NO. <u>212 10 9283</u>						18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> 4201 DUE TO (b) <u>Hypertensive C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>15 years</u> <u>5 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 12, 1952</u> to <u>April 2, 1962</u> , that (I) (we) last saw the deceased alive on <u>April 4, 1967</u> , and that death occurred at <u>6:05</u> M, from the causes and on the date stated above.													
22a. SIGNATURE <u>Edwin L. Pierpont</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>4/11/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>						22d. ADDRESS <u>8204 LIBERTY Rd - Balt, 21207 Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/5/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park</u>			23d. LOCATION (City, town or county) (State) <u>Woodlawn Md.</u>					
24. FUNERAL DIRECTOR <u>J.T. Stansbury</u> ADDRESS <u>6411 Windsor Mill Rd.</u>						25a. REC'D BY REGISTRAR <u>APR 6 1967</u> DATE			25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>				

1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04736

CERTIFICATE OF DEATH

04736

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>9 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>4213 W. Rogers Ave.</u>				d. STREET ADDRESS <u>4213 W. Rogers Ave.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rebecca</u> Middle <u>NMN</u> Last <u>Gershberg</u>				4. DATE OF DEATH Month <u>4</u> Day <u>28</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02-25-95</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AT HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>LITH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JONAS GRAZUTIS</u>				14. MOTHER'S MAIDEN NAME <u>ETHEL ELLISON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-32-3480</u>		17. INFORMANT <u>Patient's Chart</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL INFARCTION</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>7 DAYS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>a) BRONCHO PNEUMONIA</u> <u>b) HIATUS HERNIA WITH HEMORRHAGE</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		20g. (City or town) (County) (State)		20h. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-</u> , 19 <u>67</u> , to <u>4-28-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-28-</u> 19 <u>67</u> , and that death occurred at <u>10:25AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>E. K. S. Narayanan</u>				22b. DATE SIGNED <u>4-28-67</u>		22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN, M.D.</u>	
22d. ADDRESS <u>GREATER BALTO. MED. CENTER, M.D. 21204</u>				22e. ADDRESS <u>GREATER BALTO. MED. CENTER, M.D. 21204</u>		22f. ADDRESS <u>GREATER BALTO. MED. CENTER, M.D. 21204</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/30/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ANSHE EMUNAH-AITZ CHAIM</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>	
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>				25a. REC'D BY REGISTRAR <u>MAY 3 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04736

04736

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

[Faint, mostly illegible text and markings covering the page, including what appears to be a signature and various stamps.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04737

CERTIFICATE OF DEATH

04737

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in no event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY in 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			304
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 2050 E. FAYETTE STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle HENRY Last GITTINGS				4. DATE OF DEATH Month APRIL Day 4 Year 1967			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 28, 1916		9. AGE (In years lost birthday) yrs. 50	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHOE REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN FREDERICK GITTINGS				14. MOTHER'S MAIDEN NAME EMMA POLK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 219 22 90 47		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE SUPPURATIVE COLITIS DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MUCINOUS ADENOCARCINOMA OF RECTUM AND COLON WITH METASTASES DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH DAYS UNKNOWN							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHOPNEUMONIA AND PULMONARY EDEMA							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 30 , 19 67 , to APRIL 4 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 4, 1967 , and that death occurred at 150A M, from causes and on the date stated above.							
22a. SIGNATURE <i>John D. Talbert</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/4/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-7-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Cherry Wilson</i>		ADDRESS WILSON FUNERAL HOME ORLEANS ST. BALTIMORE, MD.		25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE <i>Charles J...</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04738					04738				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY <u>BALTO</u> MARYLAND					a. STATE <u>MD.</u> b. COUNTY <u>BALTO</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>				c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u> <u>03.1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>222 N. MARLYN</u>					d. STREET ADDRESS <u>222 N. MARLYN</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print) <u>ROBERT L. GOFF</u> First Middle Last					Month Day Year <u>APR. 23 1967</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 3, 1896</u>		9. AGE (In years last birthday) yrs. <u>70</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>VA.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>PAUL GOFF</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE RUTON</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W. I</u>		16. SOCIAL SECURITY NO. <u>2-16-09-6175</u>		17. INFORMANT <u>MARY GOFF</u>			Address <u>222 N. MARLYN</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>199.2</u> <u>Acute Coronary occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Indolent Carcinoma of rect.</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.									
22a. SIGNATURE <u>Wm. P. Reilly, M.D.</u>						22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>Wm. P. Reilly, M.D.</u>	
22d. ADDRESS						22e. REC'D BY REGISTRAR		22f. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>			23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD</u>		
24. FUNERAL DIRECTOR <u>J. G. CONNELLY SONS</u>						24a. REC'D BY REGISTRAR <u>APR 27 1967</u>		24b. REGISTRAR'S SIGNATURE	

04138

OFFICIAL OF DEATH

04138

1961-1-1

1961-1-1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04733

CERTIFICATE OF DEATH

04739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Balto</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN TB <u>31 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Randallstown</u>				d. STREET ADDRESS <u>P.O. Box 23</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER Balto. Med. Center</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Evelyn</u> Last <u>GORE</u>				4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1967</u>			
5. SEX <u>F.</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-24-12</u>	
9. AGE (In years last birthday) <u>54</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>NORMAN DELL</u>		14. MOTHER'S MAIDEN NAME <u>KELLEY</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>	
16. SOCIAL SECURITY NO. <u>218-26-6687</u>		17. INFORMANT <u>Adm. Notes</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Undifferentiated, retroperitoneal malignant tumor</u> DUE TO (b) <u>158X</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> a.m. p.m.				20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>3-23-</u> , 19 <u>67</u> , to <u>4-10</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/10/67</u> 19 <u>67</u> , and that death occurred at <u>1:40AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Ram K. Chhillar</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4/10/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHHILLAR</u>				22d. ADDRESS <u>GREATER BALTIMORE MED. CENTER, BALTIMORE, MD 21224.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-13-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Sykesville Md</u>	
24. FUNERAL DIRECTOR <u>Harry W. Haight Sykesville, Md</u>				25a. RECEIVED BY REGISTRAR <u>APR 12 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. J. Judge</u>	

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CENTRAL BANK

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RECEIVED BY THE BANK OF AMERICA

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Rem K. Chiller
Rem K. Chiller

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CITY OF BALTIMORE
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04740

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04740

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere		c. LENGTH OF STAY IN 1b 3 Years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2628 Marine Ave.				d. STREET ADDRESS 2628 Marine Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Sophie Middle G. Last Gover				4. DATE OF DEATH Month April Day 11 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7/26/69		9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Massachussets		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Goles				14. MOTHER'S MAIDEN NAME Mary Goles			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-22-8690		17. INFORMANT Address Husband, Mr. Howard D. Gover, #2#a,b,c,d.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Melvin B. Davis		EXAMINER'S NAME (Type) Melvin B. Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 4-12-1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 14-1967		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland 21224	
24. FUNERAL DIRECTOR John J. Duda, Dundalk, Maryland 21222				25a. REC'D BY REGISTRAR APR 14 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04741

CERTIFICATE OF DEATH

04741

1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY Allegany	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN lb 16 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Albert Last Grabenstein		4. DATE OF DEATH Month 4 Day 1 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12.9.99
9. AGE (In years last birthday) 67 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad employee	
11. BIRTHPLACE (County & State, or foreign country) Md Cumberland, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Grabenstein		14. MOTHER'S MAIDEN NAME Sarah Logson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes [no] or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 705-12-3255	
17. INFORMANT Wm Records, Mt. Wilson State Hospital		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary tuberculosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3-16-1967 to 4-1-1967 , that (I) (we) last saw the deceased alive on 4-1-1967 , and that death occurred at 1250 PM , from causes and on the date stated above.			
22a. SIGNATURE Wm Newcomer		22b. DATE SIGNED 4-1-67	
22c. PHYSICIAN'S NAME (Type) Wm Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-4-67	23c. NAME OF CEMETERY OR CREMATORY St. Peter & Paul Cemetery	23d. LOCATION (City or Town) (County) (State) Cumberland, Md.
24. FUNERAL DIRECTOR James F. Scarpelli		25a. REC'D BY REGISTRAR APR 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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252

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04742

04742

1. PLACE OF DEATH a. COUNTY Baltimore - - MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elliott	
c. LENGTH OF STAY IN 1b 141 Days		d. STREET ADDRESS 09.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOSEPH Middle HERBERT Last GRAY		4. DATE OF DEATH Month APRIL Day 14 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10/7/95
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Fishing	9. AGE (In years last birthday) yrs. 71
11. BIRTHPLACE (County & State, or foreign country) Elliott, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Gray		14. MOTHER'S MAIDEN NAME Delitha A. Horseman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 220-32-08-36	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastasis to Neck 1912 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) Squamous Cell Carcinoma, Skin, Left Pinna		INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Nov. 25 , 19 66 , to April 14 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 14 , 19 67 , and that death occurred at 9:40 PM from causes and on the date stated above.			
22a. SIGNATURE Neilon Neilson, M.D.		22b. DATE SIGNED 4/15/67	
22c. PHYSICIAN'S NAME (Type) NEILON NEILSON, M. D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/17/67	23c. NAME OF CEMETERY OR CREMATORY Elliott Cemetery	23d. LOCATION (City or Town) (County) (State) Elliott, Maryland
24. FUNERAL DIRECTOR Willoughby Funeral Home East New Market, Md.		25a. REC'D BY REGISTRAR APR 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

01510

01510

Metastasis to Neck

Squamous Cell Carcinoma, Skin, Left Chin

MELVIN NELSON, M.D.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04743

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04743

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY BALTIMORE				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY in 1b DOA	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			031	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1915 Armco Way		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Joseph Middle J. Last GREEN				4. DATE OF DEATH Month April Day 6 Year 19 67				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/21/22		9. AGE (In years last birthday) yrs. 44	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Installation		10b. KIND OF BUSINESS OR INDUSTRY Inc., Petroleum Services		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME Not Known				14. MOTHER'S MAIDEN NAME Rose Boenning				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army WWII		16. SOCIAL SECURITY NO. 216-12-2856		17. INFORMANT Address Wife, Gertrude L. Green, # 2, a, b, c, d.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED April 7, 1967		
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
				Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 10-1967		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md. 21224		
24. FUNERAL DIRECTOR ADDRESS John J. Duda, Dundalk, Md. 21222				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge		

MEDICAL CERTIFICATION

04743

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21-22-23

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04744

04744

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 30-4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 4900 Belair Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last George Howard GREIF				4. DATE OF DEATH Month Day Year April 26, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1893	
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months Days 63		11. IF UNDER 24 HRS. Hours Min. 63		12. IF UNDER 24 HRS. Hours Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME George Greif				14. MOTHER'S MAIDEN NAME Anna Martell			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 214-18-7434		17. INFORMANT Patient on admission Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma of lung. DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 10 (this hospital) attended the deceased from April 26, 1967 , to April 26, 1967 , that 10 (we) last saw the deceased alive on April 26, 1967 , and that death occurred at 4:40 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>Melencio Ventura</i> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 27, 1967	
22c. PHYSICIAN'S NAME (Type) Melencio Ventura, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5-1-67		23c. NAME OF CEMETERY OR CREMATORY Oaklawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md	
24. FUNERAL DIRECTOR Walter Dabrowski 1005 Dundalk Avenue ADDRESS				25a. REC'D BY REGISTRAR MAY 1 1967 DATE		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04740

04740

June 22, 1905

John Marshall

Patent on an Invention

of the

1905

After Proprietors' Death

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04745

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04745

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodstock			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Melrose Avenue				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First SIMON Middle F. Last GRIGGS				4. DATE OF DEATH Month April Day 5 Year 19 67			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov 16, 1917	9. AGE (In years lost, birthday) yrs. 49	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Howard Co. School		11. BIRTHPLACE (State or foreign country) Granite, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Elijah Perry Griggs				14. MOTHER'S MAIDEN NAME Wilhamina Lumpkin			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW* II		16. SOCIAL SECURITY NO. 214-20-1730		17. INFORMANT Mr. Elijah P. Griggs Woodstock, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/6/67	
EXAMINER'S NAME (Type) Charles S. Petty		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md			
24. FUNERAL DIRECTOR Herbert E. Nutter 3035 W. North Ave				25a. REC'D BY REGISTRAR Ark 11 1967		25b. REGISTRAR'S SIGNATURE Charles S. Petty	

DATE

1943

WILLIAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <i>Balto.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md.</i> b. COUNTY <i>Balto.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i> 03-1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1924 Gwynn Oak Ave.</i>		d. STREET ADDRESS <i>1924 Gwynn Oak Ave.</i>	
3. NAME OF DECEASED (Type or print) First <i>Raymond</i> Middle <i>A.</i> Last <i>Grimmer, Sr.</i>		4. DATE OF DEATH Month <i>April</i> Day <i>10</i> Year <i>1967</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 13, 1901</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Baker</i>	11. BIRTHPLACE (State or foreign country) <i>Michigan</i>
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>			
13. FATHER'S NAME <i>John G. Grimmer</i>		14. MOTHER'S MAIDEN NAME <i>Mary</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-01-7059</i>	
17. INFORMANT <i>Mr. Raymond A. Grimmer Jr.</i>		Address <i>2243 Searles Rd.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>acute congestive cardiac failure</i> DUE TO <i>ASHD.</i> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <i>10 hrs</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>1/2</i> 19 <i>65</i> to <i>4/10/67</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>4/2</i> 19 <i>67</i> , and that death occurred at <i>1 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Milton Schleuoff</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <i>Milton Schleuoff MD</i>		22d. ADDRESS <i>6410 Windsor Mill Rd</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>April 12, 1967</i>	23c. NAME OF CEMETERY OR CREMATORY <i>London PK.</i>	23d. LOCATION (City, town, or county) (State) <i>Balto. Md.</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>John T. Stansbury Sr.</i>		25a. REC'D BY REGISTRAR <i>APR 12 1967</i>	
ADDRESS <i>6411 Windsor Mill Rd.</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

10

CHIEF MAIL

DATE

01750

CERTIFICATE OF DEATH

WARRANT AND CERTIFICATE OF DEATH

John F. Grimmer
Retired Baker
Male white
Born [illegible]
Died [illegible]
Cause of death [illegible]
Place of death [illegible]
Buried [illegible]
U.S.A.

John F. Grimmer
Retired Baker
Male white
Born [illegible]
Died [illegible]
Cause of death [illegible]
Place of death [illegible]
Buried [illegible]
U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04747						04747					
1. PLACE OF DEATH a. COUNTY <u>Balto.</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. LENGTH OF STAY IN 1b <u>29 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTO. Md.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greater Balto Medical Center</u>						d. STREET ADDRESS <u>4209 1/2 Old Frederick Rd.</u>					
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>J.</u> Last <u>Groh</u>			4. DATE OF DEATH Month <u>4</u> Day <u>8</u> Year <u>1967</u>			5. SEX <u>M</u>			6. COLOR OR RACE <u>W</u>		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>4/2/90</u>			9. AGE (In years last birthday) <u>76</u> yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNKNOWN - BAKER</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Frank Groh</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Reese Ring</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u>				16. SOCIAL SECURITY NO. <u>UNKNOWN</u>				17. INFORMANT <u>Mary Hipsley</u> Address <u>4209 1/2 Old Frederick Rd</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Generalized Seizures</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Metastatic Squamous Carcinoma Mandible</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ASHD = Atrial Fibrillation; Diabetes Mellitus</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>67</u> , to <u>4/8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/8</u> 19 <u>67</u> , and that death occurred at <u>7:30</u> PM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Miguel R. Alonso</u>				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED <u>April 8, 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Miguel R. Alonso</u>				22d. ADDRESS <u>Greater Balto. Med. Center</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>April 12, 1967</u>				23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral CEM. BALTO. Md.</u>			
23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>				24. FUNERAL DIRECTOR <u>G. TRUNAN Schwab. 3512 Fred. Ave.</u>				25a. REC'D BY REGISTRAR <u>APR 11 1967</u>			
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											

THE UNIVERSITY OF MICHIGAN LIBRARY

DATE

1955



Handwritten notes and stamps, including a rectangular stamp with the word "RECEIVED" and a date stamp "APR 11 1955".

Handwritten notes and stamps, including a rectangular stamp with the word "RECEIVED" and a date stamp "APR 11 1955".

APR 11 1955

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04748

04748

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD c. LENGTH OF STAY IN 1b 121 DAYS		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EMANUEL Middle EMIL Last GROSS		4. DATE OF DEATH Month APRIL Day 16 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/97
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR Months 15 Days 15 Hours 15 Min.	11. IF UNDER 24 HRS. Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PACKER		10b. KIND OF BUSINESS OR INDUSTRY BALTIMORE, MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EMANUEL GROSS		14. MOTHER'S MAIDEN NAME MARY KING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		16. SOCIAL SECURITY NO. 218 18 95 39	
17. INFORMANT CLINICAL RECORDS, VAH, FT. HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BILATERAL FEMORAL ARTERY OCCLUSION, ACUTE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH 15 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from DECEMBER 16, 1966 , to APRIL 16, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 16, 1967 , and that death occurred at 8:10AM , from causes and on the date stated above.			
22a. SIGNATURE Louis C. Breschi		22b. DATE SIGNED 4/16/67	
22c. PHYSICIAN'S NAME (Type) LOUIS C. BRESCHI, M. D.		22d. ADDRESS VAH, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Apr. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR Gonce Funeral Home		25a. REC'D BY REGISTRAR APR 21 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Jones		25c. ADDRESS 4001 Ritchie Ave. Baltimore, Md.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04749

CERTIFICATE OF DEATH

04749

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RANDALLSTOWN</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> <u>21208</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County Gen. Hosp</u>		d. STREET ADDRESS <u>6948 Marsue Drive</u>	
3. NAME OF DECEASED (Type or print) <u>Leon H Grossman</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-6-01</u> 66
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>INS. SALESMAN</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INS. SALESMAN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ROMANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JACOB Grossman</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH</u> ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>214-03-3003</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO <u>Carcinoma of lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of lungs</u> (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-16-1967</u> , to <u>4-17-1967</u> , that (I) (we) last saw the deceased alive on <u>4-17-1967</u> , and that death occurred at <u>3:00AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Gracia R. Patricia</u>		22d. ADDRESS <u>BALTIMORE COUNTY GENERAL HOSPITAL</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/18/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>HEBREW YOUNG MEN</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MARYLAND</u>
24. FUNERAL DIRECTOR <u>SOL LEVINSON & BROS. INC., 6010 REIST., RD.</u>		25a. REC'D BY REGISTRAR <u>APR 21 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

04739

CERTIFICATE OF DEATH

04739



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

Vertical text on the right margin, likely a filing or processing stamp, containing the words "RECEIVED" and "FILED".

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04750

CERTIFICATE OF DEATH

04750

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph's Hospital		d. STREET ADDRESS 910 Fairway Drive	
3. NAME OF DECEASED (Type or print) DORA HAHN First Middle Last		4. DATE OF DEATH April 11, 1967 Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-14-1894
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Houswife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Post		14. MOTHER'S MAIDEN NAME Caroline	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Doris Haslbeck, 910 Fairway Dr. 21204		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Coronary Artery Disease Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause last. (b) Hypertensive Crisis Renal DUE TO Arteriosclerosis (c) Hypertensive Crisis Renal		INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/28, 1966 to 4/11, 1967 , that (I) (we) last saw the deceased alive on 3/27, 1967 , and that death occurred at 3:00 P. M, from causes and on the date stated above.			
22a. SIGNATURE Charles F. O'Donnell		22b. DATE SIGNED 4/13/67	
22c. PHYSICIAN'S NAME (Type) Dr. Charles F. O'Donnell		22d. ADDRESS 7501 York Road, Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-14-1967	
23c. NAME OF CEMETERY OR CREMATORY St. Pauls Lutheran Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		25a. REC'D BY REGISTRAR APR 17 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

01750

INVENTORY OF DEATH

01750

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MD
1
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04751

CERTIFICATE OF DEATH

04751

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (Rural)		c. LENGTH OF STAY IN 1b 10yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chase (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 296 Bird River Beach Road			d. STREET ADDRESS Box 296 Bird River Beach Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Edna Middle I Last Hall			4. DATE OF DEATH Month 4 Day 23 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-1915	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 12 Days 1 Hours 19 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welding		10b. KIND OF BUSINESS OR INDUSTRY Martins		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME Edward Mitchell			14. MOTHER'S MAIDEN NAME Lillian Klien		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-18-9504		17. INFORMANT Mr David K. Hall Address Box 296 Bird River Beach	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Benign Prostatic Hyperplasia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic Cancer of the breast. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from causes and on the date stated above.					
22a. SIGNATURE Wm. A. Rodger			22b. DATE SIGNED 4/25/67		22c. PHYSICIAN'S NAME (Type) Dr. Wm. A. Rodger
22d. ADDRESS 835 Eastern Avenue					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-1967		23c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery	
23d. LOCATION (City or Town) Baltimore		23e. (County) Co.		23f. (State) Md.	
24. FUNERAL DIRECTOR Lassell Funeral Home			25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

12520

5520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and on any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04752

CERTIFICATE OF DEATH

04752

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 25 DAYS			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAMPSTEAD				d. STREET ADDRESS ROUTE 1, BOX 331			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First FOSTER Middle REED Last HALL				4. DATE OF DEATH Month APRIL Day 7 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 2, 1923	
9. AGE (In years lost birthday) 43 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) PIKE COUNTY, KENTUCKY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRAFTSMAN				10b. KIND OF BUSINESS OR INDUSTRY SHIP YARD			
13. FATHER'S NAME JAMES HALL				14. MOTHER'S MAIDEN NAME OIA WRIGHT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II				16. SOCIAL SECURITY NO. 405 22 25 66		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MENINGITIS, PNEUMOCOCCUS 3401 DUE TO (b) BRAIN ABSCESS, LEFT OCCIPITAL LOBE DUE TO (c) PULMONARY EDEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS RECENT RECENT	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CRANIOTOMY, RECENT. TRACHEOSTOMY, RECENT						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/13/67 , 19__, to 4/7/67 , 19__, that (X) (we) last saw the deceased alive on 4/7/67 , 19__, and that death occurred at 7:30 AM from causes and on the date stated above.							
22a. SIGNATURE <i>Milton Ginsberg</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/7/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ADDRESS MC CULLY FUNERAL HOME				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
PATAPSCO AVENUE, BALTIMORE, MD.							

04752

04752

RECEIVED
JAN 12 1964
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK (100-100000)
SUBJECT: [Illegible]
RE: [Illegible]
[Illegible text follows, appearing to be a memorandum or report with multiple lines of text, some of which are partially obscured by the scanning process.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04753					04753									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY Baltimore					a. STATE Maryland									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 21204					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, Maryland 21207									
c. LENGTH OF STAY IN 1b 3mons +					d. STREET ADDRESS 4715 Norwood Avenue									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dulaney Towson Nursing Home, 111 West Rd					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print)			First Edwin			Middle C			Last Hanson					
4. DATE OF DEATH			Month April			Day 13			Year 1967					
5. SEX Male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1879		9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) accountant				10b. KIND OF BUSINESS OR INDUSTRY B & O R.R.				11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME William H. Hanson					14. MOTHER'S MAIDEN NAME Sugars									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no					16. SOCIAL SECURITY NO. 705-03-484					17. INFORMANT CHARLES R. HANSON - 2111 Waterford Rd Dulaney Towson Nursing Home, 111 West Road				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the prostate gland with generalized metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) this hospital attended the deceased from 1950 to March , 1967, that (I) was last saw the deceased alive on March , 1967, and that death occurred at 4:30 P.M. from the causes and on the date stated above. 22a. SIGNATURE William F. Traband 22b. DATE SIGNED 4/13/67 22c. PHYSICIAN'S NAME (Type) MILLARD F. TRABAND JR 22d. ADDRESS 1811 North Colling Rd. BALTIMORE, MD. 21207 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4-17-67 23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery - Baltimore, Md 23d. LOCATION (City, town or county) (State) BALTIMORE, MD. 24. FUNERAL DIRECTOR Ellsworth ARMALIST - 4601 Liberty Heights Ave 25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge DATE APR 19 1967														

62520

2530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04754

CERTIFICATE OF DEATH

04754

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ba Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hospital</u>		d. STREET ADDRESS <u>2111 Southland Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Edwin</u> First Middle <u>NMN</u> Last <u>Hansson</u>		4. DATE OF DEATH Month <u>4</u> Day <u>10</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-16-83</u>
9. AGE (In years last birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>10</u> Hours <u>19</u> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Pa Water & Power Co.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Sweden</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Andrew Hansson</u>		14. MOTHER'S MAIDEN NAME <u>Jane Hudson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>212-07-2040</u>	
17. INFORMANT <u>Mrs. Anna T. Hansson</u>		Address <u>2111 Southland Rd</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>Myocardial failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASHD</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>2/10/60</u> , 19__ to <u>4/8/67</u> , 19__, that (I) (we) last saw the deceased alive on <u>4/8/67</u> , 19__, and that death occurred at <u>9 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Milton Schlenker</u>		22b. DATE SIGNED <u>4/11/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Milton Schlenker</u>		22d. ADDRESS <u>2111 Southland Rd</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-13-1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Woodlawn Md.</u>
24. FUNERAL DIRECTOR <u>G. Howard Strong 3207 W. North Ave.,</u>		25a. REC'D BY REGISTRAR DATE <u>APR 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

0520

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Baltimore County MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN lb 2 years. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY Anne Arundel c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shady Side d. STREET ADDRESS Avery Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) HARDIN Mabel			First Middle Last HARDIN			4. DATE OF DEATH 4 / 13 / 1967			Month Day Year		
5. SEX F.		6. COLOR OR RACE White.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 10/30/1908		9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Massachusetts.			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Edwin Head.						14. MOTHER'S MAIDEN NAME Mary Martin.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT Address Records, Mount Wilson State Hospital					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 0021 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Post. left Pneumonectomy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Pulmonary Tuberculosis										INTERVAL BETWEEN ONSET AND DEATH 2 days 68 days	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 4-7 , 19 65 , to 4-13 , 19 67 , that (I) (we) last saw the deceased alive on 4-13 , 19 67 , and that death occurred at 8:45 A.M., from the causes and on the date stated above.											
22a. SIGNATURE Wm. Newcomer						ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent						22d. ADDRESS Mount Wilson, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE THEREOF April 15/67			23c. NAME OF CEMETERY OR CREMATORY Woodfield			23d. LOCATION (City, town or county) (State) Galesville Md.		
24. FUNERAL DIRECTOR TA Hancher						ADDRESS Galesville, Md		25a. REC'D BY REGISTRAR APR 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04755

04755

Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records Section

Records, Mount Wilson State Hospital

Mr. Newcomer, M.D., Superintendent, Mount Wilson, Maryland

APR 11 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04756

CERTIFICATE OF DEATH

04756

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>—</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		c. LENGTH OF STAY in 1b <u>8 yrs.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St. Petersburg</u> <u>483</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Md. Masonic Home</u>			d. STREET ADDRESS <u>7403 - 46th Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Ann</u> Last <u>Nare</u>			4. DATE OF DEATH Month <u>April</u> Day <u>7</u> Year <u>1967</u>		
5. SEX <u>Fe.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>October 12, 1888</u>	9. AGE (In Years) <u>88</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Co. Md.</u>	
13. FATHER'S NAME <u>William Bowen</u>			14. MOTHER'S MAIDEN NAME <u>Margaret Lase</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-54-63449</u>		17. INFORMANT <u>Records of Md. Masonic Home</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Aspiration Bronchopneumonia</u> DUE TO (c) <u>Seizure - y - fracture hip</u>					INTERVAL BETWEEN ONSET AND DEATH <u>approx 2 Months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 11, 1965</u> , to <u>April 7, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 7, 1967</u> , and that death occurred <u>at 4:45</u> M, from causes and on the date stated above.					
22a. SIGNATURE <u>Jamshid Hamed</u>			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED</u>			22d. ADDRESS <u>MASONIC HOME</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/10/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MARYLAND</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook-Brooks TOWSON</u>			25a. REC'D BY REGISTRAR <u>APR 11 1967</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

0328

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THE UNIVERSITY OF CHICAGO

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04757

CERTIFICATE OF DEATH

04757

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 3 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 8623 WENDELL AVENUE	
3. NAME OF DECEASED (Type or print) First HENRY Middle G. Last HARTMAN		4. DATE OF DEATH Month APRIL Day 10 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 9/21/91
9. AGE (In years lost birthday) yrs. 75		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. BIRTHPLACE (County & State, or foreign country) ROSSVILLE, MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME CHARLES HARTMAN	
14. MOTHER'S MAIDEN NAME HILDA MILLER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I	
16. SOCIAL SECURITY NO. 213 10 85 75		17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) (c) INTERVAL BETWEEN ONSET AND DEATH RECENT		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE WITH CEREBRAL EDEMA AND PULMONARY EDEMA	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 m.p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 4/7/67 , 19__, to 4/10/67 , 19__, that (X) (we) last saw the deceased alive on 4/10/67 , 19__, and that death occurred at 6:30PM , from causes and on the date stated above.			
22a. SIGNATURE J. D. Talbert		22b. DATE SIGNED 4/11/67	
22c. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 4-13-1967	
23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ASSAHN FUNERAL HOME		25a. REC'D BY REGISTRAR APR 12 1967	
25b. REGISTRAR'S SIGNATURE W. J. Judge		25c. DATE APR 12 1967	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04758

CERTIFICATE OF DEATH

04758

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. LENGTH OF STAY IN 1b <u>4 1/4 YRS.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		d. STREET ADDRESS <u>303 main ST</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>303 main Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nannie Ann Heath</u>		4. DATE OF DEATH <u>April 19, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>AUG. 26, 1902</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Presser</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Laundry</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Drakes Branch, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Spencer Lee</u>		14. MOTHER'S MAIDEN NAME <u>Maggie Dunvill</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>217-20-4563</u>	
17. INFORMANT <u>James W. Heath</u>		Address <u>303 main ST</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY congestion</u> DUE TO (b) <u>HAEMIA</u> DUE TO (c) <u>Nephritis-Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>7 days</u> <u>30 days</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 19, 1900</u> to <u>April 19, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 19, 1967</u> , and that death occurred at <u>10:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Wade</u>		22b. DATE SIGNED <u>April 19, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Wade, M.D.</u>		22d. ADDRESS <u>140 Oak Ave. Dundalk 22, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-23-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Charles R. Law, 802 Madison Ave.</u>		25. REC'D BY REGISTRAR <u>APR 24 1967</u>	
26. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04758

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Back

Discharge

Baltimore

303 Main St
April 18 1914

Annals 32

303 Main Street

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Frank Church

Presser

Spencer Lee

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Wendell Charles Brown, Va
Wendell Brown

315-303 Main St

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June 10th 1914

April 1914

William C. Wood

William C. Wood, M.D.

April 1914

Wendell Brown

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04753 CERTIFICATE OF DEATH 04759

1. PLACE OF DEATH a. COUNTY Balto.		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 Week		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital: Home address) Dulaney-Towson Nursing Home, 111 West Rd.						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Martha		First Ruth		Middle Helbruck		4. DATE OF DEATH Month 4		Day 29		Year 1967	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 13, 1897		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) E. St. Louis, Ill.			12. CITIZEN OF WHAT COUNTRY? U.S.		
13. FATHER'S NAME Samuel William Wright Gullion				14. MOTHER'S MAIDEN NAME Mary Jane Garrish				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			
16. SOCIAL SECURITY NO. 345-24-9168				17. INFORMANT Mrs. Jeannette M. Collins				Address 501 Garnett Rd.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Abdominal carcinomatosis</u> 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <u>4-27</u> , 19 <u>67</u> , and that death occurred at <u>3:10</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Richard K Gundry</u>								22b. DATE SIGNED <u>4-29-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard K Gundry</u>	
22d. ADDRESS <u>2 W University Pkwy, 21218</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery				23d. LOCATION (City, town or county) St. Clair, Illinois			
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks Towson 1050 York Rd. 21204						25a. REC'D BY REGISTRAR DATE MAY 2 1967		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <div>1</div> <div>04760</div> </div> <div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> </div> <div> <div>04760</div> </div> </div>									
1. PLACE OF DEATH a. COUNTY Baltimore County b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson c. LENGTH OF STAY IN 1b 1 yr. 8 1/2 mo d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Mount Wilson State Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD. b. COUNTY CECIL c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CONOWINGO 172 RURAL d. STREET ADDRESS 172 RURAL e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) JOHN ALEXANDER HENDERSON First Middle Last 4. DATE OF DEATH 4 12 1967 Month Day Year					5. SEX M 6. COLOR OR RACE NEGRO 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 11/5/1900 9. AGE (In years last birthday) 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER 10b. KIND OF BUSINESS OR INDUSTRY General 11. BIRTHPLACE (County & State, or foreign country) Balt. Co. Md. 12. CITIZEN OF WHAT COUNTRY? USA					13. FATHER'S NAME AMOS HENDERSON 14. MOTHER'S MAIDEN NAME BLANCHE HALL				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 216-10-9447 17. INFORMANT Records, Mount Wilson State Hospital Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY TUBERCULOSIS 2021 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic obstructive airway disease 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from 27 July , 1965, to 12 April , 1967, that (I) (we) last saw the deceased alive on 12 April 1967, and that death occurred at 4 P.M. from the causes and on the date stated above.									
22a. SIGNATURE Wm. Newcomer 22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent 22b. DATE SIGNED 12 April 67 ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Mount Wilson, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 23b. DATE THEREOF 4/17/67 23c. NAME OF CEMETERY OR CREMATORY Mt. Zoar Cemetery 23d. LOCATION (City, town or county) (State) Conowingo, Md.									
24. FUNERAL DIRECTOR Richard L. Goodie 25a. REC'D BY REGISTRAR APR 17 1967 25b. REGISTRAR'S SIGNATURE Charles Judge									

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04761

CERTIFICATE OF DEATH

04761

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 20 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 201 S. Symington Avenue				d. STREET ADDRESS 201 S. Symington Ave.			
3. NAME OF DECEASED (Type or print) First Middle Last Ernest Owens Hepding				4. DATE OF DEATH Month Day Year Apr. 23, 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 20, 1905	
9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor				10b. KIND OF BUSINESS OR INDUSTRY C & P. Telephone Co. Baltimore Co., Md.		11. BIRTHPLACE (County & State, or foreign country) U. S. A.	
13. FATHER'S NAME Augustus Hepding				14. MOTHER'S MAIEN NAME Margaret E. Cornthwaite			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 212-05-0656		17. INFORMANT Catonsville, Md. 21228 Mrs. Margaret A. Hepding 201 S. Symington Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Ischemic							INTERVAL BETWEEN ONSET AND DEATH Ischemic
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe Emphysema							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from 2/24, 1967 , to 4/23, 1967 , that (I) (we) last saw the deceased alive on 4/14, 1967 , and that death occurred at CA. M. from causes on and on the date stated above.							
22a. SIGNATURE Cliff Ratliff				22b. DATE SIGNED 4/24/67		22c. PHYSICIAN'S NAME (Type) CLIFF RATLIFF, MD	
22d. ADDRESS 4605 Edmondson on #25							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/1967		23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		23d. LOCATION (City or Town) (County) (State) Ellicott City, Maryland	
24. FUNERAL DIRECTOR Easton Funeral Home				25a. REC'D BY REGISTRAR DATE APR 27 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MINISTRE DE LA SÉCURITÉ

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VR A15 (4)
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04762

CERTIFICATE OF DEATH

04762

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>—</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Nursing Home</u>		d. STREET ADDRESS <u>2919 Hamilton Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Hergenroeder, Sr.</u> Last <u>Hergenroeder</u>		4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 8, 1881.</u>
9. AGE (In years lost birthday) <u>85</u> yrs.		10. IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Baker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bakery</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-32-2358A</u>	
17. INFORMANT <u>Mr. Henry R. Hergenroeder Sr.</u>		Address <u>5336 Perring Pkwy Balto. Md. #14</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> 4/21 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ASCVD with heart failure</u> DUE TO (c) <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>20 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/29</u> , 19 <u>66</u> , to <u>4/21</u> , 19 <u>67</u> , that (I) (we) lost saw the deceased alive on <u>4/21</u> , 19 <u>67</u> , and that death occurred at <u>12:10</u> PM, from causes and on the date stated above.			
22a. SIGNATURE <u>James E. Rowe</u> M.D.		22b. DATE SIGNED <u>4-21-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James E. Rowe</u>		22d. ADDRESS <u>5550 Baltimore National Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/24/67.</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04188

04188

Postoffice
319 Union Ave.

Sept. 6, 1901.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04763

04763

1. PLACE OF DEATH a. COUNTY Baltimore, Towson MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb 39 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS 1007 South Carey			
3. NAME OF DECEASED (Type or print) Hignutt, Kenneth		First Middle Last Hignutt		4. DATE OF DEATH 4 18 1967		Month Day Year	
5. SEX Male		6. COLOR OR RACE CAU.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-18-09	
9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY STEEL		11. BIRTHPLACE (County & State, or foreign country) QUEEN ANNES Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Hignutt				14. MOTHER'S MAIDEN NAME Duloff NORA DULIN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 28-28-9567		17. INFORMANT WIFE Mrs. Henrietta Hignutt Address 1007 S. Carey St. Baltimore, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY OEDEMA 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARDIAC FAILURE DUE TO (c) CARCINOMA OF LUNG WITH METASTASES						INTERVAL BETWEEN ONSET AND DEATH 9 days 9 days UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 67 , to 4/28 , 19 67 , that (I) (we) last saw the deceased alive on 4/28 19 67 , and that death occurred at 6:30 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Derek A Bruce				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/28/67	
22c. PHYSICIAN'S NAME (Type) DEREK A. BRUCE				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF MAY 1, 1967		23c. NAME OF CEMETERY OR CREMATORY CHESTERFIELD CEMETERY		23d. LOCATION (City or Town) (County) (State) CENTREVILLE, O.A. Co Md.	
24. FUNERAL DIRECTOR James H. Barton Jr. Barton Box, Centerville, Md.				25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04753

04753

TEMPERATURE OF ORIGIN

Paterson, New Jersey

Greater Baltimore Medical Center
Highway, Route 1
11-28-09 31
Map 644

Queen Anne's Co. 112

William Huggins
Duff

Commonwealth with Petitioner
CARDIAC FAILURE
LEGALLY DEAD
9 days
9 days
Unknown

Derek A Bruce
Derek H Bruce
4/28/03 3/1/03 4/28/03
4/28/03

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04764

CERTIFICATE OF DEATH

04764

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. LENGTH OF STAY IN 1b <u>2 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>809 Dartmore Road Lutherville</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>				d. STREET ADDRESS <u>807 Dartmore Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>STEWART LAWRENCE HILL</u>				4. DATE OF DEATH Month Day Year <u>APRIL 26, 1967</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-19-1916</u>	
9. AGE (In years lost birthday) <u>50</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TECH. CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BALTO. GASKELEC.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>UNKNOWN</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>215-09-9748</u>				17. INFORMANT <u>Patient's Chart</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE ANTERO-LATERAL MYOCARDIAL INFARCTION.</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE.</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>3</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-24-</u> , 19 <u>67</u> , to <u>4-26-</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-26-</u> , 19 <u>67</u> , and that death occurred at <u>6:35AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>E. K. S. Narayanan</u>				22b. DATE SIGNED <u>4-26-1967</u>		22c. PHYSICIAN'S NAME (Type) <u>E. K. S. NARAYANAN, M.D.</u>	
22d. ADDRESS <u>GREATER BALTO. MEDICAL CENTER, TOWSON, MARYLAND 21204.</u>				22e. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr. 29, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Landon Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>John Burne's Sons, Towson, Md.</u>				25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01782

01782

MAY 1967

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04765

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04765

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8 N. Beechwood Ave</u>				d. STREET ADDRESS <u>8 N. Beechwood Ave</u>			
3. NAME OF DECEASED (Type or print) <u>Helen</u> First Middle Last				4. DATE OF DEATH <u>April 23 1967</u> Month Day Year			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 4, 1911</u>	
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COST ACCOUNTANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ACCOUNTING</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NORTH CAROLINA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S</u>							
13. FATHER'S NAME <u>C. C. SWAIN</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE PICKETT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>W. Himes</u> Address <u>8 N. Beechwood Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrhythmia</u> <u>416X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Rheumatic heart disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Previous embolization to brain, kidneys, spleen</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) [this hospital] attended the deceased from <u>Feb. 13, 1967</u> , to <u>April 17, 1967</u> , that (I) <u>(a)</u> last saw the deceased alive on <u>April 17, 1967</u> , and that death occurred at <u>TEM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>David W. Morse</u>				22b. DATE SIGNED <u>4/26/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>David W. Morse M.D.</u>				22d. ADDRESS <u>University Hospital</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		23b. DATE THEREOF <u>4/26/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louison Park</u>		23d. LOCATION (City, town or county) (State) <u>BALTO. Md.</u>	
24. FUNERAL DIRECTOR <u>E. S. MacNabb</u>				ADDRESS <u>301 Frederick Rd</u> <u>BALTO 28 Md</u>		25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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On June

On June

Catonsville

Catonsville

2 N Beechwood Ave

2 N Beechwood Ave

Helen

Helen

W

Feb. 11, 1911

Cost Accountant

Accounting

North Carolina

C. C. Swann

Florence Pickett

no

no

no

no

no

no

no

no

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04766

CERTIFICATE OF DEATH

04766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RANDALLSTOWN			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) BALTIMORE COUNTY GENERAL HOSPITAL				d. STREET ADDRESS 4720 PARK HEIGHTS AVENUE			30-1
3. NAME OF DECEASED (Type or print) EDYTHE J. HOFFMAN First Middle Last				4. DATE OF DEATH APRIL 7, 1967 Month Day Year			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-25-04		9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME JOSEPH ELOVER				14. MOTHER'S MAIDEN NAME LENA ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 218-12-6511		17. INFORMANT Address MR. PHILIP HOFFMAN, 4720 PARK HEIGHTS AVE.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis 156.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma Liver DUE TO (c) Metastatic Carcinoma Lung							INTERVAL BETWEEN ONSET AND DEATH 1967
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour : a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 1958 to 4/7 , 19 67 , that (I) (we) last saw the deceased alive on 4/7 19 67 and that death occurred at 2:30 PM , from causes and on the date stated above.							
22a. SIGNATURE E. S. Hallinan				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/8/67	
22c. PHYSICIAN'S NAME (Type) DR. EDWARD KALLINS				22d. ADDRESS LIBERTY HEIGHTS AVENUE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/9/67	23c. NAME OF CEMETERY OR CREMATORY ADATH JESHURUN ADDRESS		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04786

04786

BALTIMORE

BALTIMORE

BALTIMORE

BALTIMORE

BALTIMORE COUNTY GENERAL HOSPITAL

4720 PARK HEIGHTS AVENUE

EDYTH

WOMAN

APRIL 7

FEMALE WHITE

12-25-04

HOSPITAL

AT HOME

EDYTH

JOSEPH FLOWER

LEWIS

NO

218-12-4511

MR. THOMAS HOBBS, 4720 PARK HEIGHTS AVE.

DR. EDWARD KALLING

4720 PARK HEIGHTS AVENUE

MURKIN

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APR 11 1967

NOT RECORDED & INDEXED... 1000 11200000

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove urban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04767

CERTIFICATE OF DEATH

04767

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Prince George	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 3½ yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS 2105 Roxanne Court	
3. NAME OF DECEASED (Type or print) First Sylvia Middle Anne Last HOLT		4. DATE OF DEATH Month 4 Day 23 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-13-63
9. AGE (In years last birthday) 4 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Landon Burton Holt, Jr.		14. MOTHER'S MAIDEN NAME Mary Anne Young	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia 543X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Aspiration of Stomach Contents DUE TO (c) Acute Gastritis & Gastroenteritis		INTERVAL BETWEEN ONSET AND DEATH 1 hr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from 6/21 , 19 63 , to 4/23 , 19 67 , that he (we) last saw the deceased alive on 4/23 , 19 67 , and that death occurred at 7:15 A.M. from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 24 April 1967	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/26/67	
23c. NAME OF CEMETERY OR CREMATORY Alex. NATIONAL CEMETERY		23d. LOCATION (City or Town) (County) (State) ALEX., VIRGINIA	
24. FUNERAL DIRECTOR Robert E. Wilhelm Funeral Home 4308 Suitland Road, Suitland, Maryland		25a. REC'D BY REGISTRAR DATE APR 26 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. CDUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. CDUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rosedale	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7314 Philadelphia Rd.		d. STREET ADDRESS 7314 Philadelphia Rd.	
3. NAME OF DECEASED (Type or print) Russell C. Hood		4. DATE OF DEATH Month April Day 23 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 25, 1893
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY Railroad	
11. BIRTHPLACE (State or foreign country) Balto. Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Unknown Hood		14. MOTHER'S MAIDEN NAME Leona Summers	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes # 1		16. SOCIAL SECURITY NO. 705 07 1564	
17. INFORMANT Mrs. Eliz. Hood		Address 7314 Phila Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4801 DUE TO HCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exogenous obesity		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Theo C Patterson		22. DATE SIGNED 4/24/67	
EXAMINER'S NAME (Type) THEO. C PATTERSON		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4 26 1967	
23c. NAME OF CEMETERY OR CREMATORY Balto. U. S. National		23d. LOCATION (City, town or county) (State) Balto. Md.	
24. FUNERAL DIRECTOR Mc Gully		ADDRESS 130 E. Port Ave	
25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

00180

00180

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04763

CERTIFICATE OF DEATH

04769

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home		d. STREET ADDRESS 5713 Edmondson Ave A4	
3. NAME OF DECEASED (Type or print) First Middle Last Mary Elizabeth Hopkins		4. DATE OF DEATH April 14, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 10, 1876
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co. Md		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Thomas Howes		14. MOTHER'S MAIDEN NAME Georgianna Schekells	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mary Edna Hopkins - Same		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X DUE TO Cerebro-vascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Generalized arterio sclerosis DUE TO Age (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March, 1967 to April 14, 1967 , that (I) (we) last saw the deceased alive on April 13, 1967 , and that death occurred at 5:30 AM , from causes and on the date stated above.			
22a. SIGNATURE J. J. Volenick		22b. DATE SIGNED 4/15/67	
22c. PHYSICIAN'S NAME (Type) Lee J. Volenick MD		22d. ADDRESS 4710 Liberty Hts Ave	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-17-67	23c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md
24. FUNERAL DIRECTOR ELLSWORTH ARMACOST-4610 Liberty Hgts		25a. REC'D BY REGISTRAR Charles J. J...	
25b. REGISTRAR'S SIGNATURE Charles J. J...		DATE APR 19 1967	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04770

CERTIFICATE OF DEATH

04770

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 504 Academy Rd. 21228		d. STREET ADDRESS 504 Academy Rd. 21228	
3. NAME OF DECEASED (Type or print) First Katherine Middle E. Last Horton		4. DATE OF DEATH Month April Day 22 , Year 67	
5. SEX Female	6. COLOR OR RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 12/87
9. AGE (In years lost birthday) 79 yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____ IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Balto., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ----- Arnreich		14. MOTHER'S MAIDEN NAME Unk.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Philip McKenna 504 Academy Rd. - 21228		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Coronary Artery Disease DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH Minutes Year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Myocardial Infarction March 1967			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 'a.m. _____ p.m. _____ 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 1967, to 4/22 , 1967, that (I) was saw the deceased alive on 4/21 , 1967, and that death occurred at 3:4 M, from causes and on the date stated above.			
22a. SIGNATURE James Nolan		22b. DATE SIGNED 4/22/67	
22c. PHYSICIAN'S NAME (Type) Jas. J. Nolan		22d. ADDRESS 1 Mallow Hill Rd.	
23a. BURIAL CREMATION, etc. (Specify) Burial	23b. DATE THEREOF 4/25/1967	23c. NAME OF CEMETERY OR CREMATORIUM New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore Maryland
24. FUNERAL DIRECTOR Witzke Funeral Dir. 4101 Edmondson Ave.		25a. REC'D BY REGISTRAR DATE APR 25 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04770

04770

White

White

White

White

White

SON Academy Rd. 21238

SON Academy Rd. 21238

April 22

April 22

Apr. 22/57

Apr. 22/57

Apr. 22/57

USA

USA

USA

USA

USA

SON Academy Rd. - 21238

1 Willow Hill Rd.

1 Willow Hill Rd.

Baltimore Maryland

New Cathedral

4/22/1957

Baltimore

1957

Albino (squirrel) 4711 Richmond Ave.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04771

CERTIFICATE OF DEATH

04771

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>				c. LENGTH OF STAY IN 1b <u>22 yrs.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10 Linden Terrace, Pikesville 8, Md.</u>				d. STREET ADDRESS <u>10 Linden Terrace</u>			
3. NAME OF DECEASED (Type or print) First <u>Nancy</u> Middle <u>Elizabeth</u> Last <u>Houck</u>				4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>19 67</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Sept. 7, 1885</u>		9. AGE (In years lost birthday) <u>81</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert Louis Green</u>				14. MOTHER'S MAIDEN NAME <u>Stella Bookman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Charles Elmer Houck, 10 Linden Terrace, Pikesville 8, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic disease</u> DUE TO (c) <u>Viral infection</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 hrs</u> <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fracture Ribs</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-1-</u> , 19 <u>67</u> to <u>4-9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-8-</u> , 19 <u>67</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>James G. Saffell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-11-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell</u>		22d. ADDRESS <u>Reisterstown, Md</u>					
23a. BURIAL (CREMATION, REMOVAL) (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 12, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR <u>Frank H. Yarnall</u>				ADDRESS <u>Pikesville 8, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 19 1967</u>	
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04772

CERTIFICATE OF DEATH

04772

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY in 1b <u>3wks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		21208	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. CO. GEN. HOSP</u>				d. STREET ADDRESS <u>Nelson Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EDWARD EVERETT HUGHES</u>				4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-26-95</u>	
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward E. Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Jamie Chaffman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-019025</u>		17. INFORMANT <u>Hosp.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>White Medullary Collapse</u> DUE TO <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-27-1967</u> to <u>4/17/67</u> , that (I) (we) last saw the deceased alive on <u>4/17/67</u> , and that death occurred at <u>10:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Gocombell</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gocombell</u>				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>April 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Cemetery</u>		23d. LOCATION (City or town) (County) (State) <u>Pikesville 8, Md.</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>				25a. REC'D BY REGISTRAR <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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ENTRANCE OF DEATH

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U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN lb <u>11 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore 21218</u> d. STREET ADDRESS <u>645 McKewin</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Annie</u> <u>M. Jackson</u>					4. DATE OF DEATH Month <u>April</u> Day <u>21</u> Year <u>1967</u>				
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-1875</u>		9. AGE (In years last birthday) <u>92</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>New York city, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph W. Mattingly</u>					14. MOTHER'S MAIDEN NAME <u>Lettie Ann Jarboe</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>218-52-1108</u>		17. INFORMANT <u>Hospice records</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Draining chest wall Sinus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u>ASCVD</u>									INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4-14-56</u> , 19 <u>67</u> , to <u>4-21-</u> 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-21-67</u> , 19 <u>67</u> , and that death occurred at <u>1.04 PM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>R. J. Mahon, MD</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4-21-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>R. J. Mahon, MD</u>					22d. ADDRESS <u>204 E. Joppa Rd.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Balto. Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Brooks Towson, Towson, Md. 21204</u>						25a. REC'D BY REGISTRAR <u>APR 25 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF BIRTH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND
04774 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04774

1. PLACE OF DEATH a. COUNTY Baltimore		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		c. LENGTH OF STAY IN 1b 65 yrs		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 7101 Fait Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Frances		First Frances		Middle Janiszewski		Last Janiszewski		4. DATE OF DEATH 4-25		Month 4		Day 25		Year 1967	
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-1886		9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY home				11. BIRTHPLACE (State or foreign country) Poland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME Unknown											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 2I6-09-70I5B				17. INFORMANT Frances Sauer 7101 Fait Avenue							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cerebral vascular accident 443X DUE TO H241A Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) H241A DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county) These fallers H20 C P A Persu DATE SIGNED 4/26/67															
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 4-29-67				22c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cemetery				22d. LOCATION (City, town, or country) (State) Baltimore, Maryland			
23. FUNERAL DIRECTOR Walter Dabrowski				ADDRESS I005 Dundalk Avenue				24a. REC'D BY REGISTRAR MAY 1 1967				24b. REGISTRAR'S SIGNATURE Charles Judge			

MEDICAL CERTIFICATION

Walter Dabrowski 1005 Dumbell Avenue

MAY 1 1961

Walter Dabrowski 1005 Dumbell Avenue

Walter Dabrowski
1005 Dumbell Avenue

X

210-00-70158 Frances Sauer 7101 Fair Avenue

Walter Dabrowski
1005 Dumbell Avenue

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 20 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 2614 FOSTER AVENUE	
3. NAME OF DECEASED (Type or print) First FRANK Middle JOSEPH Last JASKOWICK		4. DATE OF DEATH Month APRIL Day 25 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 7/9/1897 AGE (In years last birthday) 70 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SHEARMAN		10b. KIND OF BUSINESS OR INDUSTRY STEEL COMPANY	
11. BIRTHPLACE (County & State, or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME PETER JASKOWICK		14. MOTHER'S MAIDEN NAME JOANNA LOGODZINSKA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 216 10 50 41	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CARCINOMA OF FLOOR OF MOUTH WITH METASTASES DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 DAYS UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (if) (this hospital) attended the deceased from 4/5/67 , 19 to 4/25/67 , 19, that (if) (we) last saw the deceased alive on 4/25/67 , 19, and that death occurred at 2:10 P M, from causes and on the date stated above.			
22a. SIGNATURE <i>Milton Ginsberg</i>		22b. DATE SIGNED 4/25/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-28-67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND
24. FUNERAL DIRECTOR KACZEROWSKI FUNERAL HOME		25a. REC'D BY REGISTRAR MAY 1 1967	
ADDRESS ROSE & FLEET ST. BALTIMORE, MD.		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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STATE OF NEW YORK

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IN SENATE

January 1, 1911

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1910

ALBANY: JAMES B. LEECH, STATE PRINTER, 1911.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE
04776
CERTIFICATE OF DEATH 04776

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>325 Stratford Rd.</u>		d. STREET ADDRESS <u>325 Stratford Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>H.</u> Last <u>JENKINS</u>		4. DATE OF DEATH <u>April 19, 1967</u> 19	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 10, 1898</u> 68 yrs.
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Brokers</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward F. Jenkins</u>		14. MOTHER'S MAIDEN NAME <u>Agnes M. Hamilton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-09-6878</u>	
17. INFORMANT <u>Mrs Marguerite C. Jenkins</u>		Address <u>325 Stratford Rd.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSIVE & ARTERIO</u> <u>SCLEROTIC CARDIOVASCULAR</u> <u>DISEASE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 mos +</u> (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4/18</u> , 19 <u>67</u> , to <u>4/19</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/18</u> , 19 <u>67</u> , and that death occurred at <u>10:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Thos E Roach</u>		22b. DATE SIGNED <u>4/20/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thos E Roach</u>		22d. ADDRESS <u>5550 Bartonville Pike</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Apr 22, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemt</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>STERLING FUNERAL ESTATE</u>		25a. REC'D BY REGISTRAR <u>APR 24 1967</u>	
ADDRESS <u>736 Edm. Av. Catonsville, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No.

04777

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk				c. LENGTH OF STAY IN 1b 2 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 6904 Mornington Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CLARENCE Middle CHESTER Last JOLLETT				4. DATE OF DEATH Month April Day 5th Year 19 67			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 11, 1883	
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sheet Metal Worker		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Burton L. Jollett				14. MOTHER'S MAIDEN NAME Louise Sullivan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 213-07-1709A		17. INFORMANT Address Mrs. Cora M. Jollett, same as #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) coronary thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) myocardial ischemia DUE TO (c) arteriosclerotic heart disease							INTERVAL BETWEEN ONSET AND DEATH 1 year
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from _____, 19____, to 4/5 , 19 67 , that I last saw the deceased alive on 4/5 , 19 67 , and that death occurred at 9:30A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE Eugene F. Nevy M.D. 7001 Mornington Road 4/6/67 PHYSICIAN'S NAME (Type) Eugene F. Nevy, M.D. Dundalk, Maryland 21222							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4/8/67		22c. NAME OF CEMETERY OR CREMATORY Meadowridge Memorial		22d. LOCATION (City, town, or county) (State) Dorsey, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Walter Brooks Bradley, Inc., Dundalk 21222				24a. REC'D BY REGISTRAR APR 10 1967		24b. REGISTRAR'S SIGNATURE J. Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04778

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04778

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgemere - 19				c. LENGTH OF STAY IN lb Hours			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Bay... Old Bay Shore Park				d. STREET ADDRESS 18 A Westway South 21220			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Frank Middle LEONARD Last Jones				4. DATE OF DEATH Month April Day 17 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 26- 1943		9. AGE (In years last birthday) 23 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance-Construction Office Trailer				10b. KIND OF BUSINESS OR INDUSTRY Mfg. Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ralph Jones				14. MOTHER'S MAIDEN NAME Helen Ragan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 219-40-5116		17. INFORMANT Wife, Margaret A. Jones, #2,a,b,c,d.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Boat Swamped + Threw MAN IN WATER			
20c. TIME OF INJURY Month, Day, Year 12:01 4-17 1967				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Ches Bay	
				20f. (City or town) Edgemere - Baltor Md-		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M B Davis				CHIEF MEDICAL EXAMINER <input type="checkbox"/> 4-17-1967			
EXAMINER'S NAME (Type) Melvin B. Davis				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				M.D. 6800 Mornington Rd. Dundalk, Md. 21222			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 19-1967		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Maryland	
24. FUNERAL DIRECTOR Foster Funeral Home, Bel Air, Maryland				ADDRESS W. B. & Williams		25a. REC'D BY REGISTRAR APR 19 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04779

04779

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN TB 18 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30.4			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 794 GRANTLEY AVENUE St.			
3. NAME OF DECEASED (Type or print) First HAROLD Middle C. Last JONES				4. DATE OF DEATH Month APRIL Day 25 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/12/10		9. AGE (In years last birthday) 57 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) JANITOR		10b. KIND OF BUSINESS OR INDUSTRY STEEL CO.		11. BIRTHPLACE (County & State, or foreign country) PITTSYLVANIA, VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HENRY JONES				14. MOTHER'S MAIDEN NAME POKIE CRAFT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 218 07 66 23		17. INFORMANT Address CLIN.RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC INSUFFICIENCY 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PYELONEPHRITIS, KLEBSIELLA AEROBACTER; STATUS SUBTOTAL GASTRECTOMY FOR DUODENAL ULCER							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (A) (this hospital) attended the deceased from 4/7/67 , 19 67 , to 4/25/67 , 19 67 , that (A) (we) last saw the deceased alive on 4/25/67 , 19 67 , and that death occurred at 1:25 AM , from causes and on the date stated above.							
22a. SIGNATURE <i>Neilson Neilson</i> M.D.				22b. DATE SIGNED 4/25/67		22c. PHYSICIAN'S NAME (Type) NEILSON NEILSON, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-28-67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR MORTEN & DYETT FUNERAL HOME				25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE <i>John Jones</i>	
ADDRESS 1701 LAURENS ST. BALTIMORE, MD.							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04780

CERTIFICATE OF DEATH

04780

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 304	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 25 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 645 BARTLETT AVENUE	
3. NAME OF DECEASED (Type or print) First JAMES Middle ALBERT Last JONES		4. DATE OF DEATH Month APRIL Day 24 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11 21 12
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STOCK MAN		10b. KIND OF BUSINESS OR INDUSTRY CLOTHING MFG.	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN JONES		14. MOTHER'S MAIDEN NAME EDITH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW-11		16. SOCIAL SECURITY NO. 218 01 85 72	
17. INFORMANT CLIN. REC., VAH, FT. HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) SPONTANEOUS PNEUMOTHORAX LEFT, MASSIVE 162-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PULMONARY EMPHYSEMA, MARKED DUE TO (c) BRONCHOGENIC CARCINOMA RIGHT UPPER LOBE		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY CONGESTION & EDEMA. ARTERIOSCLEROTIC HEART DISEASE.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (if this hospital) attended the deceased from 3/30/67 , 19 to 4/24/67 , 19, that (we) last saw the deceased alive on 4/24/67 , 19, and that death occurred at 5:15AM from causes and on the date stated above.			
22a. SIGNATURE <i>Peter V. Juvan</i>		22b. DATE SIGNED 4/24/67	
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/24/1967	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.	
24. FUNERAL DIRECTOR <i>Marshall P. Hayes</i>		25. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

MARSHALL P. HAYES FUNERAL HOME
N. GILMOR ST. BALTIMORE, MD.
APR 25 1967

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04781

04781

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DOGWOOD RD. RT. 5</u>				d. STREET ADDRESS <u>DOGWOOD RD. RT. 5</u>			
3. NAME OF DECEASED (Type or print) First <u>BERTHA C.</u> Middle <u>KAHLER</u> Last <u>KAHLER</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 10, 1885</u>	
9. AGE (In years lost birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FREDERICK STIRN</u>				14. MOTHER'S MAIDEN NAME <u>EVA STIRN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-36-1897D</u>		17. INFORMANT Address <u>Mr. G. EDWIN KAHLER DOGWOOD RD RT. 5</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma, Erythroid</u> <u>203X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes</u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u> <u>10 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 15</u> to <u>APRIL 26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/24</u> , 19 <u>67</u> , and that death occurred at <u>6A</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>Thomas E. Wheeler</u>				22b. DATE SIGNED <u>APR 27 1967</u>			
22c. PHYSICIAN'S NAME (Type) <u>THOMAS E. WHEELER MD</u>				22d. ADDRESS <u>RANDALLSTOWN - MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>APRIL 28, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT. OLIVE</u>		23d. LOCATION (City, town, or county) (State) <u>RANDALLSTOWN MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>JOHN T. STANSBURY, SR.</u>				ADDRESS <u>4411 WINDSOR MILL RD.</u>		25a. REC'D BY REGISTRAR <u>John T. Stansbury</u>	
25b. REGISTRAR'S SIGNATURE <u>John T. Stansbury</u>				DATE <u>APR 27 1967</u>			

1878

CERTIFICATE OF DEATH

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APR 21 1881

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04782

04782

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural, Baltimore</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3343 Washington Avenue</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>rural, Baltimore</u> d. STREET ADDRESS <u>3343 Washington Avenue</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>E.</u> Last <u>Kandefer</u>			4. DATE OF DEATH Month <u>April</u> Day <u>22</u> , Year <u>1967</u>				
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 3, 1908</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Comptometer operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Cloverland Dairy</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Taylor, Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Michael Reichwalder</u>			14. MOTHER'S MAIDEN NAME <u>Barbara Mitnick</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-10-9493</u>	17. INFORMANT <u>Edward W. Kandefer Sr.</u> <u>3343 Washington Ave Balto 7. Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Clinical carcinoma stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>16 mo.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	(County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 31, 1966</u> , to <u>April 22, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 21, 1967</u> , and that death occurred at <u>3:04 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Harry Kelmenson</u> M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>April 22, 1967</u>		
22c. PHYSICIAN'S NAME (Type) <u>Harry Kelmenson</u>			22d. ADDRESS <u>2 E. Read Street Balto. Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/26/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St John's Catholic Church</u>		23d. LOCATION (City or Town) (County) (State) <u>Taylor Penna.</u>	(County) (State)		
24. FUNERAL DIRECTOR <u>Spring Byers</u> <u>8728 Liberty Rd Randallstown Md</u>			25a. REC'D BY REGISTRAR DATE <u>APR 24 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04783

CERTIFICATE OF DEATH

04783

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>BALTO.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ESSEX</u>		c. LENGTH OF STAY IN 1b <u>ESSEX</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>799 SILVER AVE</u>		d. STREET ADDRESS <u>799 SILVER AVE</u>	
3. NAME OF DECEASED (Type or print) First <u>PATRICK J.</u> Middle <u>KEARNS</u> Last <u>KEARNS</u>		4. DATE OF DEATH Month <u>APR</u> - Day <u>25TH</u> Year <u>1967</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT-4-1907</u>
9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN KEARNS</u>		14. MOTHER'S MAIDEN NAME <u>MARY CURRAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>ELLA KEARNS (WIFE)</u>		Address <u>SAME AS ABOVE</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peripheral vascular collapse</u> <u>154X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>carcinomatous</u> DUE TO (c) <u>Carcinoma of rectosigmoid</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 mo</u> <u>8 mo</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cachexia, complete small bowel obstruction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>67</u> , to <u>25 April</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>21 April</u> 19 <u>67</u> , and that death occurred at <u>8 AM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>S. J. DeMarco III</u>		22b. DATE SIGNED <u>4/26/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. J. DeMarco, III, M.D.</u>		22d. ADDRESS <u>715 N. Charles ST.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/28/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>GARDENS OF FAITH</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO - CO. - MD</u>	
24. FUNERAL DIRECTOR <u>J.G. CONNELLY SONS</u>		25a. REC'D BY REGISTRAR <u>300 MACE AVE</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		DATE <u>MAY 1 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 04784

04784

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore Rural				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mercy Villa Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Kelly				4. DATE OF DEATH Month April Day 23 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 9, 1890	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeping Nurse				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? United States							
13. FATHER'S NAME Joseph Kelly				14. MOTHER'S MAIDEN NAME Sarah E. Lynch			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-16-3737		17. INFORMANT Sister M. Carlotta, R.S.M., Mercy Villa	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4801 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic Cardio-Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 8-10 yrs				INTERVAL BETWEEN ONSET AND DEATH 3 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 5-2 , 19 67 , to 4-23 , 19 67 , that I last saw the deceased alive on 4-23 , 19 67 , and that death occurred at 7:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Philip D. Flynn				ADDRESS (Street, city or town, state) 11 E. Chase St. Baltimore Md.			
DATE SIGNED 4/24/67							
PHYSICIAN'S NAME (Type) Philip D. Flynn, M. D.							
22a. BURIAL, CREMATION, REBURYAL (Specify) Burial		22b. DATE THEREOF 4/26.67.		22c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery		22d. LOCATION (City, town, or county) (State) Long Green, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck, Inc. Balto. Md. 21214				24a. REC'D BY REGISTRAR APR 27 1967		24b. REGISTRAR'S SIGNATURE Charles Judge	



U.S. ARMY AND STATE DEPARTMENT OF HEALTH - BALTIMORE 11

STANLEY, J. W. & CO., INC.,

10. *How many people are there in your family?*

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04785

CERTIFICATE OF DEATH

04785

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> <u>CANDALLS TOWN</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b <u>2 WKS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. COUNTY GENERAL HOSPITAL</u>	
d. STREET ADDRESS <u>707 ST. PAUL ST</u> <u>XXXXXXXXXXXXXX</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>HOLMES</u> <u>H.</u> <u>KENNERLY</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>25</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>7/18/89</u>
9. AGE (In years lost birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CHAUFFEUR STANDARD OIL</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RIVERTON, MD.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RIVERTON, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>	
13. FATHER'S NAME <u>ANDREW J. KENNERLY</u>		14. MOTHER'S MAIDEN NAME <u>MARY MARGARET BENNETT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>B.J. KENNERLY</u>		Address <u>707 ST. PAUL ST.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO <u>1021</u> (b) <u>Bronchogenic carcinoma</u> DUE TO <u> </u> (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <u>3 mths</u> <u>1 yr?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/10</u> , 19 <u>67</u> , to <u>4/25</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/25</u> , 19 <u>67</u> , and that death occurred at <u>8A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Maurice Feldman Jr</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>MAURICE FELDMAN JR</u>		22b. DATE SIGNED <u>4/25/67</u>	
22d. ADDRESS <u>2 E READ ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/29/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RIVERTON CEMETERY</u>		23d. LOCATION (City or Town) (County) (State) <u>RIVERTON, MD.</u>	
24. FUNERAL DIRECTOR <u>H.W. MEARS & SON</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>			

04785

CERTIFICATE OF DEATH

04785

PAUL ST. JAMES

2 WBS

TO

RETIRED GRANITE STANDARD

ANNEX 1. KENNEDY

W. J. KENNEDY FOR ST. PAUL ST.

WILKINSON, W.

4/30/57

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W. J. KENNEDY FOR ST. PAUL ST.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04786

04786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their phrase remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 304			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 8 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21217		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1928 BRUNT STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SAMUEL Middle LEE Last KESTON, JR.				4. DATE OF DEATH Month APRIL Day 21 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/96		9. AGE (In years last birthday) yrs. 71	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SAMUEL LEE KESTON, SR.				14. MOTHER'S MAIDEN NAME JOHNSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 218 05 59 39		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH HOURS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (at) this hospital attended the deceased from 4/13/67 , 19____, to 4/21/67 , 19____, that (at) (we) last saw the deceased alive on 4/21/67 , 19____, and that death occurred at 11:05 AM from causes on and on the date stated above.							
22a. SIGNATURE CONRADO L. MANCAO, M.D.				22b. DATE SIGNED 4/21/67		22c. PHYSICIAN'S NAME (Type) CONRADO L. MANCAO, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-26-67		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery Baltimore, Maryland		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Charles Law Funeral Home				25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04787

CERTIFICATE OF DEATH

04787

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Hall			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Perry Hall Medical Center				d. STREET ADDRESS 6008 Eunice Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Helen Middle I. Last Kijowski				4. DATE OF DEATH Month April Day 5 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 1, 1898.	9. AGE (In years last birthday) yrs. 68	10. IF UNDER 1 YEAR Months 30 Days 4 Hours 4 Min.		11. IF UNDER 24 HRS. Months 30 Days 4 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland / Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Frank Shanofski				14. MOTHER'S MAIDEN NAME Kendzrejewski Frances Gzelnick			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-22-1104		17. INFORMANT Mrs. Edward M. Gregory		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral heart disease 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb 2, 1959 , to Apr. 5, 1967 , that (I) (we) last saw the deceased alive on Feb 2, 1967 , and that death occurred at 2:30 M, from causes and on the date stated above.							
22a. SIGNATURE Donald Jandorf M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-6-67	
22c. PHYSICIAN'S NAME (Type) Dr. Donald Jandorf				22d. ADDRESS 6077 Harford Road			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/67.		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck Inc. 5305 Harford Rd. #14				25a. REC'D BY REGISTRAR APR 7 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04787

EXTRACT OF DEED

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #13 & 14 Film#G388 1/26/67 pc

04788

CERTIFICATE OF DEATH

04788

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 6220 Mossway	
3. NAME OF DECEASED (Type or print) First Middle Last Winona G. KING		4. DATE OF DEATH Month Day Year April 21 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 10, 1888
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months Days Hours Min. 78	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Teacher		10b. KIND OF BUSINESS OR INDUSTRY Education-Balto. City Minn.	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Eugene Greiman		14. MOTHER'S MAIDEN NAME Carrie/ Virginia Boyer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 820-00-5426	
17. INFORMANT Alton B. King		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 578X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse intestinal bleeding. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Atherosclerosis, generalized, marked.		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 8 , 19 67 , to April 21 , 19 67 , that (I) (we) last saw the deceased alive on April 21 , 19 67 , and that death occurred at 5:45 M. from causes and on the date stated above.			
22a. SIGNATURE Juane S. Cockburn		22b. DATE SIGNED April 21, 1967	
22c. PHYSICIAN'S NAME (Type) Juane S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/1967	
23c. NAME OF CEMETERY OR CREMATORY Prospect Hill		23d. LOCATION (City or Town) (County) (State) York Pa/	
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Road Balto. 12, Md.		25a. REC'D BY REGISTRAR APR 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04789

CERTIFICATE OF DEATH

04789

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 30-4	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE - 21224	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 219 N. LINWOOD AVENUE	
3. NAME OF DECEASED (Type or print) First FREDERICK Middle J. Last KOEHLER		4. DATE OF DEATH Month APRIL Day 17 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/9/96
9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months 70 Days 70 Hours 70 Min. 70	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SPECIAL POLICE		12. INDUSTRY DETECTIVE AGENCY	
13. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME ANDREW KOEHLER		16. MOTHER'S MAIDEN NAME ANNA MURPHY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		18. SOCIAL SECURITY NO. 218 07 77 14	
19. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ARTERIOSCLEROTIC HEART DISEASE (b) ARTERIOSCLEROTIC HEART DISEASE (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
23. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		24. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
25. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		26. (City or town) (County) (State)	
27. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/7/67 , 19 67 , to 4/17/67 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/17/67 , 19 67 , and that death occurred at 1:40 PM , from causes and on the date stated above.			
28. SIGNATURE J. D. Talbert		29. DATE SIGNED 4/18/67	
30. PHYSICIAN'S NAME (Type) JOHN D. TALBERT, M. D.		31. ADDRESS VAH FORT HOWARD, MARYLAND	
32. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		33. DATE THEREOF 4/20/67	
34. NAME OF CEMETERY OR CREMATORY LOUDEN PARK NATIONAL		35. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
36. FUNERAL DIRECTOR Joseph N. Zannino		37. ADDRESS ZANNINO FUNERAL HOME	
38. DATE APR 21 1967		39. REGISTER'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pikesville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Milford Manor Nursing Home</u>		d. STREET ADDRESS <u>3503 Hilton Road</u>	
3. NAME OF DECEASED (Type or print) First <u>JOSEPH</u> Middle <u>L.</u> Last <u>KOGAN</u>		4. DATE OF DEATH <u>April 24,</u> 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>80</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Printer</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LEON ? Samuel Kogan</u>		14. MOTHER'S MAIDEN NAME <u>Sarah ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>Mr. Sylvan B. Kogan, 6014 Woodcrest Avenue</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>443 X Cardio-Respiratory Failure, Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>Arteriosclerotic C V H D</u> DUE TO (b) <u>Gen & Cerebral Arteriosclerosis</u> (c) <u>Gen & Cerebral Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 5</u> , 19 <u>60</u> , to <u>April 24</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>April 24</u> , 19 <u>67</u> , and that death occurred at <u>6:25 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Willard Applefeld</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>4-24-67</u>
22c. PHYSICIAN'S NAME (Type) <u>Dr. Willard Applefeld</u>		22d. ADDRESS <u>5801 Park Heights Avenue</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/27/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Workmen Circle</u>	23d. LOCATION (City or town) (County) (State) <u>Baltimore, Maryland</u>
24. FUNERAL DIRECTOR <u>Sol Levinson & Bros. Inc., 6010 Reist., Rd.</u>		25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film G388 4/28/67 hr

04791

CERTIFICATE OF DEATH

04791

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Baltimore b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2613 Taylor Ave				d. STREET ADDRESS 2613 Taylor Ave			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Julia M Kolb				4. DATE OF DEATH Month April Day 22 Year 1967			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 20 1882	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months 1 Days 4		11. IF UNDER 24 HRS. Hours 1 Min. 45			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (County & State, or foreign country) Germany	
13. FATHER'S NAME Julius Wirth				14. MOTHER'S MAIDEN NAME Martha Faulk			
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mrs Lillian M Monninger Address 2613 Taylor Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma colon 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 1 yr.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb , 19 56 , to April 24 , 19 67 , that (I) (we) last saw the deceased alive on April 22 , 19 67 , and that death occurred at 5:45 M, from causes and on the date stated above.							
22a. SIGNATURE Stephen J. Van Lill III M.D.				22b. DATE SIGNED APR 25 1967			
22c. PHYSICIAN'S NAME (Type) Stephen J. Van Lill III, M.D.				22d. ADDRESS 3506 N. Calvert 21218			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF April 25/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore	
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road				25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04792

04792

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE 21229</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SUMMIT CONV. HOME</u>				d. STREET ADDRESS <u>124 MALBROOK RD</u>			
3. NAME OF DECEASED (Type or print) <u>AMELIA M. KROEDEL</u> First Middle Last				4. DATE OF DEATH <u>APRIL 27</u> 19 <u>67</u> Month Day Year			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/17/92</u>	9. AGE (In years lost birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WM. HOCHLER</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH SCHMIDT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>MRS JOSEPH RUTH</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of</u> <u>1750</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Ovary (Benign)</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>67</u> , to <u>April 27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>April 27</u> , 19 <u>67</u> , and that death occurred at <u>7:00</u> M., from causes and on the date stated above.							
22a. SIGNATURE <u>J. Nelson McKay</u>				22b. DATE SIGNED <u>April 28, 1967</u>		22c. PHYSICIAN'S NAME (Type) <u>J. NELSON MCKAY, M.D.</u>	
22d. ADDRESS <u>6014 EDMONDSON AVE</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/11/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR <u>E. S. MALNABB</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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UNITED STATES OF AMERICA

04135

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

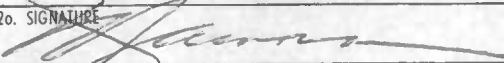
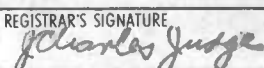
VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04793

CERTIFICATE OF DEATH

04793

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21218 30.4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1206 Cochran Rd. AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Caroline A. Kuehn				4. DATE OF DEATH Month Day Year April 17 19 67			
5. SEX Female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/9/95	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME Frederick W. Frederick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT Address William F. Kuehn, 1312 Northview Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Anterior Myocardial Infarction DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (he) (this hospital) attended the deceased from April 11, 1967 , to April 17, 1967 , that (he) (we) last saw the deceased alive on April 17, 1967 , and that death occurred at 8:20 PM , from causes and on the date stated above.							
22a. SIGNATURE 				22b. DATE SIGNED April 17 1967		22c. PHYSICIAN'S NAME (Type) Ismael O. Jamora	
22d. ADDRESS 7620 York Rd. Baltimore, Md. 21204							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/67		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Parkville, Md.	
24. FUNERAL DIRECTOR ADDRESS Ulrich Funeral Home 4210 Belair Road.				25a. REC'D BY REGISTRAR DATE APR 24 1967		25b. REGISTRAR'S SIGNATURE 	

MEDICAL CERTIFICATION

04133

STATE OF TEXAS

04133

IN SENATE,
January 11, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.
BY
J. M. HARRIS,
COMMISSIONER.
DALLAS: THE TEXAS BOOK CONCERN, 1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

2 1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #9 Film #G388 5/3/67 pc

04794

CERTIFICATE OF DEATH

04794

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>30.4</u> <u>2209 Fleetwood Ave. - Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center</u>		d. STREET ADDRESS <u>2209 Fleetwood Ave - Balto</u>	
3. NAME OF DECEASED (Type or print) <u>KUZE</u> (last) First <u>Augusta</u> Middle <u>Schadna</u>		4. DATE OF DEATH Month <u>4</u> Day <u>22</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/1/97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore City</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John HAGEDORN</u>		14. MOTHER'S MAIDEN NAME <u>Thompson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>PT. CHART.</u>		Address <u> </u>	
1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-18-</u> , 19 <u>67</u> , to <u>4/22</u> , 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4-22-</u> 19 <u>67</u> and that death occurred at <u>11:45AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>RCHILLAR</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>RAM K. CHILLAR</u>		22d. ADDRESS <u>GTR BALTO MED CENTER</u> <u>BALTIMORE MD 21204</u>	
23a. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/25/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Immanuel Cem</u>		23d. LOCATION (City or town) (County) (State) <u>Balto Md</u>	
24. FUNERAL DIRECTOR <u>Addelemani</u>		25a. REC'D BY REGISTRAR <u>APR 28 1967</u>	
ADDRESS <u>7007 6067 Hayf...</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01350

CERTIFICATE OF DEATH

01350

1. Name of deceased: [illegible]
2. Sex: [illegible]
3. Age: [illegible]
4. Date of birth: [illegible]
5. Date of death: [illegible]
6. Place of death: [illegible]
7. Cause of death: [illegible]
8. Signature of physician: [illegible]
9. Signature of registrar: [illegible]
10. Date of registration: [illegible]

11. Name of informant: [illegible]
12. Address of informant: [illegible]
13. Signature of informant: [illegible]
14. Date of completion: [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04795

CERTIFICATE OF DEATH

04795

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shady Nook Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Katherine Middle J. Last Lassalle		4. DATE OF DEATH Month 4 Day 17 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/3/1872
9. AGE (In years last birthday) 95 yrs.		10. IF UNDER 1 YEAR Months 17 Days 17 Hours 17 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Milliner		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Lassalle		14. MOTHER'S MAIDEN NAME Anna Corliss	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ---		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Dorothy M. Canton		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 332X IMMEDIATE CAUSE (a) Senescent Atherosclerosis DUE TO Cerebral Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Ischemia (c) Ischemia		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 4, 1956 to April 7, 1967 , that (I) (we) last saw the deceased alive on 4/7/1967 , and that death occurred at 1:15 P.M. from causes on the date stated above.			
22a. SIGNATURE John C. Healy		22b. DATE SIGNED 4/18/67	
22c. PHYSICIAN'S NAME (Type) John Healy		22d. ADDRESS 1311 Francis Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/20/67	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR APR 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04732

04732

John H. Gorman, Jr.

John H. Gorman, Jr.

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John H. Gorman, Jr.

John H. Gorman, Jr.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
2DM 1/65

04796

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04796

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u> 031	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Greenspring Avenue</u>		d. STREET ADDRESS <u>Ridge Road</u>	
3. NAME OF DECEASED (Type or print) <u>Lillie Eleanor Ledley</u>		4. DATE OF DEATH <u>April 9, 1967</u> 19 <u>19</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 29, 1878</u>
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>03</u> Days <u>1</u> Hours <u>00</u> Min. <u>00</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		13. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
14. FATHER'S NAME <u>John W. Hoffman</u>		15. MOTHER'S MAIDEN NAME <u>Georgiana Williams</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. SOCIAL SECURITY NO. <u>None</u>	
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) <u>None</u>		19. INFORMANT <u>Family records</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of st. Breast</u> 170X DUE TO (b) <u>metastases to lungs</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>cachexia</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month <u>April</u> Day <u>9</u> Year <u>1967</u> Hour a.m. <u>11</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1-1-1940</u> to <u>4-9-1967</u> , that (I) (we) last saw the deceased alive on <u>4-8-67</u> and that death occurred at <u>3:45</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>James G. Saffell MD</u>		22b. DATE SIGNED <u>4-10-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>James G. Saffell MD</u>		22d. ADDRESS <u>Reisterstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 12, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Grace Falls Rd. Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Lutherville, Md.</u>
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

01130

01130

01130

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04797

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04797

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN It 14 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GBMC				d. STREET ADDRESS 8700 Raven Drive Apt. A		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lela Middle Clyde Last Lee				4. DATE OF DEATH Month 4 Day 19 Year 19 67			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/03/99		9. AGE (In years lost birthday) 67 yrs.	10. UNDER 1 YEAR Months 4 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) N. Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph Burchett				14. MOTHER'S MAIDEN NAME Cora Ellen Hill			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 4331		17. INFORMANT Mr. Walter Lee, Same as # Two			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema and Pneumonia 4331 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Ventricular Fibrillation and Cardiac DUE TO (c) Arrest						INTERVAL BETWEEN ONSET AND DEATH 8 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) During Abdominal Surgery					
20c. TIME OF INJURY Month, Day, Year 13:00 p.m. April 11 19 67		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) Hospital		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell		EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/19/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 21, 1967		23c. NAME OF CEMETERY OR CREMATORY Hereford Baptist Cemetery		23d. LOCATION (City or Town) (County) (State) Hereford, Baltimore Co., Md.	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Maryland 21204				25a. REC'D BY REGISTRAR APR 21 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04757

12520

100

7.2.2.

22

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04798

CERTIFICATE OF DEATH

04798

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY in 1b 11 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		d. STREET ADDRESS 6 N. Maderia Street	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First PHILIP Middle EARL Last LEESON, Sr.		4. DATE OF DEATH Month April Day 21 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 10, 1931
9. AGE (In years last birthday) 36 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Assembly Operator		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Md.	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Floyd Leeson		14. MOTHER'S MAIDEN NAME Mabel Malone	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes PL-28		16. SOCIAL SECURITY NO. 217 26 15 84	
17. INFORMANT Clinical Rcds. VA Hospital, Ft Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEPATIC COMA 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) LAENNEC'S CIRRHOSIS DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH DAYS YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 10 , 19 67 , to April 21 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 21 , 19 67 , and that death occurred at 4:30 P. , from causes and on the date stated above.			
22a. SIGNATURE Paulino D. Deocampo		22b. DATE SIGNED 4/22/67	
22c. PHYSICIAN'S NAME (Type) PAULINO D. DEOCAMPO, M.D.		22d. ADDRESS VA Hospital, Fort Howard, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-67	
23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Hartley Miller Funeral Home		25a. REC'D BY REGISTRAR 2334 Jefferson St. Balto., Md.	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 25 1967	

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Washington

Washington

Baltimore

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10 W. Webster Street

Washington Administration Hospital

April

March 10

March 10

March 10

March 10, 1938

March 10, 1938

Baltimore, Md.

Baltimore, Md.

Robert Malone

Robert Malone

217 25 12 04 Washington, D.C.

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DATE

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04793

04799

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowleys Quarters		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bowleys Quarters	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 15, Box 560		d. STREET ADDRESS Route 15, Box 560	
3. NAME OF DECEASED (Type or print) First Middle Last William P. E. Leicht		4. DATE OF DEATH Month Day Year April 5, 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 17, 1890
9. AGE (In years lost birthday) yrs. 76		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Producer		10b. KIND OF BUSINESS OR INDUSTRY Theatres	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Adam P. Leicht		14. MOTHER'S MAIDEN NAME Elizabeth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-32-3216	
17. INFORMANT Wm. P. Leicht		Address Route 15, Box 56- 21220	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE M. B. Davis		M.D. M-D	
EXAMINER'S NAME (Type) M. B. Davis		22. DATE SIGNED 4/6/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/8/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Co. Md.	
24. FUNERAL DIRECTOR Ullrich Funeral Home 4210 Belair Road.		25a. REC'D BY REGISTRAR APR 10 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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1 **FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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04800

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04800

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mount Wilson, Md.		c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount Wilson State Hospital				d. STREET ADDRESS 9300 Carney Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Kemper Leonhardt				4. DATE OF DEATH Month Day Year 4/ 27 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/4/03	9. AGE (In years lost birthday) 63 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Leonhardt				14. MOTHER'S MAIDEN NAME Barbara Kemper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-3822		17. INFORMANT Address Records, Mount Wilson State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic R_x Obstructive Resp. Disease 5772 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic Cor Pulmonale DUE TO (c) Chronic Bronchitis						INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardio Vascular disease 5 yrs						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None		20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE D.D. CAPLES		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/27/67	
EXAMINER'S NAME (Type) D.D. CAPLES		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/67.		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25. REC'D BY REGISTRAR DATE APR 28 1967		25b. REGISTRAR'S SIGNATURE J. Charles Juge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04801

CERTIFICATE OF DEATH

04801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b <u>2 Years</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>6908 Marsue Drive</u>				d. STREET ADDRESS <u>6908 Marsue Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Maurice</u> Middle <u>Levin</u> Last <u>Levin</u>				4. DATE OF DEATH Month <u>April</u> Day <u>15</u> Year <u>19 67</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Postman</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Samuel Levin</u>				14. MOTHER'S MAIDEN NAME <u>Goldie Linden</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>219-16-5375</u>		17. INFORMANT Address <u>Mrs. Augusta Levin 6908 Marsue Drive</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, Generalized</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (lost): (b) <u>Carcinoma of prostate</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 mo</u> <u>1 1/2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> to <u>Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr 14</u> , 19 <u>67</u> , and that death occurred at <u>5:52 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Irvin Sauber</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED <u>Apr 16, 67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Dr. Irvin Sauber</u>				22d. ADDRESS <u>6905 Park Heights Avenue</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 16, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Beth Hamedrosh Hagodol</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Sol Levinson & Bros. 6010 Reisterstown Road</u>				25a. REC'D BY REGISTRAR DATE <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

04801

04801

CERTIFICATE OF DEATH

Name of Deceased		Date of Birth		Sex	
John Doe		1900-01-01		Male	
Place of Birth		Date of Death		Cause of Death	
New York, N.Y.		1950-01-01		Heart Disease	
Occupation		Residence		Burial Place	
Teacher		123 Main St.		Cemetery	
Signature of Physician		Signature of Registrar		Signature of Witness	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Issuance		Official Seal	
1950-01-01		New York, N.Y.		[Seal]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04802

CERTIFICATE OF DEATH

04802

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		c. LENGTH OF STAY IN 1b <u>14 Yrs.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		d. STREET ADDRESS <u>1260 Locust Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1260 Locust Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Jean E. Link</u>		4. DATE OF DEATH Month <u>April</u> Day <u>4</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>September 15 1924</u>
9. AGE (In years last birthday) <u>42</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward J. Peach</u>		14. MOTHER'S MAIDEN NAME <u>Mary Brewer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Garville E. Link</u>		Address <u>1260 Locust Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Cervix</u> DUE TO (b) <u>General Carcinomatosis</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not While <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Jan</u> , 1967, to <u>April 4</u> 1967 that (I) <u>(we)</u> last saw the deceased alive on <u>April 4</u> 1967, and that death occurred at <u>3:00</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>B. B. Brumbaugh</u> M.D.		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Bruce B. Brumbaugh</u>		22d. ADDRESS <u>5609 Main St, Ellicott City Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/7/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fountain Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>Amber Dr. 1328 Sulphur Sp Rd</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

07805

UNITED STATES OF AMERICA

07805

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04803

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exparted within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04803

CERTIFICATE OF DEATH

04803

Right Circulatory Collapsus
Complicated Carcinoma
Abdominum Great

Death
Apr 1907

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04804

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #4 Film #G387 4/17/67 pc

04804

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>REISTERSTOWN</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>913 Lindellen Ave</u>			d. STREET ADDRESS <u>913 Lindellen Ave</u>		
3. NAME OF DECEASED (Type or print) First <u>SARA</u> Middle <u>MAE</u> Last <u>LUtz</u>			4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1967</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JAN. 18, 1912</u>	9. AGE (In years last birthday) <u>55</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School Cafeteria</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Newberry, York PA.</u>	
13. FATHER'S NAME <u>ROY WINTER</u>			14. MOTHER'S MAIDEN NAME <u>SARA KONTZ</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>203-10-1520</u>		17. INFORMANT <u>GLORIA L. WHAREN</u> Address <u>913 Lindellen Ave</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Malnutrition (vomiting dehydration)</u> DUE TO Candidians, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Multiple Myeloma</u> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 6</u> , 19 <u>64</u> , to <u>Apr. 12</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 12</u> , 19 <u>67</u> , and that death occurred at <u>9:06 AM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>Martin E. Strobel</u>			22b. DATE SIGNED <u>4-12-67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>			22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>April 14, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SALEM, CEM</u>		23d. LOCATION (City or Town) (County) (State) <u>ETTERS RD #1 PA.</u>	
24. FUNERAL DIRECTOR <u>Henry J. Eckhardt</u>		ADDRESS <u>Quincy Mills</u>		25a. REC'D BY REGISTRAR DATE <u>APR 13 1967</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

03204

CERTIFICATE OF DEATH

03204

APR 13 1987

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

34836

04836

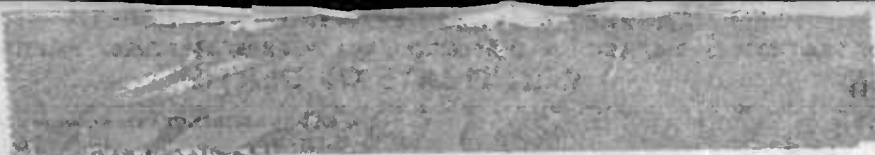
1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CATONSVILLE c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 919 VANDERWOOD ROAD		2. USUAL RESIDENCE (Where deceased lived, if institution; residence prior to admission) a. STATE MARYLAND b. COUNTY BALTO. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE d. STREET ADDRESS 919 VANDERWOOD RD	
3. NAME OF DECEASED (Type or print) HELEN First NACFALSKI Middle A Last		4. DATE OF DEATH 4 Month 17 Day 1967 Year	
5. SEX F		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-18-1890	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) POLAND		13. CITIZEN OF WHAT COUNTRY? USA	
14. FATHER'S NAME MARION WISNIEWSKI		15. MOTHER'S MAIDEN NAME APOLONIA PURZYNSKI	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		17. SOCIAL SECURITY NO. 213-10-1966A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia (Terminal) DUE TO (b) Cardio-Vascular Disease & Complications DUE TO (c) 9 Months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		19. INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		20. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22a. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
23. I certify that (I) (this hospital) attended the deceased from 2/23 19 63 to 4/17 19 67 , that (I) (we) last saw the deceased alive on 4/17 19 67 , and that death occurred at 6:45 P M, from the causes and on the date stated above.		24. SIGNATURE Eliot W. Johnson M.D. 24b. ADDRESS 3432 FREDERICK AVE.	
25a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		25b. DATE THEREOF 4-21-1967	
25c. NAME OF CEMETERY OR CREMATORY HOLY ROSARY CEMETERY		25d. LOCATION (City, town or county) (State) BALTO MD	
26. FUNERAL DIRECTOR'S SIGNATURE JOHN M. WEBER & SONS INC 4015 CHESTER ST.		26b. REC'D BY REGISTRAR APR 20 1967	
26c. REGISTRAR'S SIGNATURE J. Charles George		26d. DATE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon #2. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

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[The remainder of the page contains extremely faint, illegible text, likely bleed-through from the reverse side. Two dark circular marks are visible on the right margin.]

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04805

04805

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Towson Convalescent Home</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glyndon</u> d. STREET ADDRESS <u>118 Butler Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>S.</u> Middle <u>Raymond</u> Last <u>MacLellan</u>				4. DATE OF DEATH Month <u>April</u> Day <u>20</u> Year <u>19 67</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 21, 1886</u>		9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Md. Steel Prod.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u> </u>			
13. FATHER'S NAME <u>Harry H. MacLellan</u>				14. MOTHER'S MAIDEN NAME <u>Nellie Maud James</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>214-01-0325 A</u>		17. INFORMANT Address <u>Mrs. C. R. MacLellan 118 Butler Rd.</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Generalized Atherosclerosis</u>								INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> to <u>Apr 19 67</u> that (I) (we) last saw the deceased alive on <u>Apr 19 67</u> and that death occurred at <u>10 P</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>William G. Helfrich</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/22/67</u>			
22c. PHYSICIAN'S NAME (Type) <u>William G. Helfrich</u>						22d. ADDRESS <u>5006 Roland Ave - Baltimore, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>4/24/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>				23d. LOCATION (City, town or county) <u>Baltimore, Md.</u> (State)	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Fickner Jones</u>						25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate has been retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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STATE OF NEW YORK
IN SENATE
January 11, 1908
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
MAY 1, 1907
ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS.
1908.

ALBANY: J. B. LIPPINCOTT & COMPANY, PRINTERS.
1908.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04807

04806

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harwood Park</u> 21027			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Rt#16 Box 458 South River Drive</u>				e. STREET ADDRESS <u>Box 458 South River Drive</u>			
3. NAME OF DECEASED (Type or print) First <u>HOWARD</u> Middle <u>NEILSON</u> Last <u>MAGSAMEN</u>				4. DATE OF DEATH Month <u>4</u> Day <u>2</u> Year <u>1967</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-6-1914</u>		9. AGE (in years last birthday) <u>52</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Dairy</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Rudolph Magsamen</u>			
14. MOTHER'S MAIDEN NAME <u>Minnie E. Bevans</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>213-01-6869</u>				17. INFORMANT Address <u>Chase, Md.</u> <u>Mrs Noreine Magsamen South River Drive</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Coronary Occlusion</u> <u>4201</u> DUE TO <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Theo C. Patterson</u>				22. DATE SIGNED <u>4/3/67</u>			
EXAMINER'S NAME (Type) <u>THEO. C. PATTERSON</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-5-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Co. Md.</u>	
24. FUNERAL DIRECTOR <u>Lassahn Funeral Home 7401 Balduin Road</u>				25a. REC'D BY REGISTRAR (34) <u>APR 4 1967</u> DATE			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, the funeral director should be notified immediately. The word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MEDICAL TREATMENT CENTER, HICKS DE GRANT

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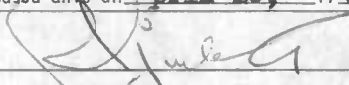
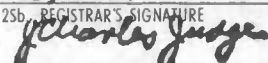
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VR A15 (4)
25M 1/67

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		03-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1251 Halstead Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Silver		Middle Paul		Last MAHER	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		4. DATE OF DEATH Month April	
				8. DATE OF BIRTH August 22, 1892		9. AGE (In years lost birthday) 74 yrs.	
				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland	
				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Thomas W. Maher				14. MOTHER'S MAIDEN NAME Matilda M. Wheeler			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 212-05-4338		17. INFORMANT Mrs. Ann M. Maher		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Acute respiratory insufficiency 1621 DUE TO malignant tumor, left pleural cavity. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. { DUE TO (b) Bronchogenic carcinoma of the right lung with massive extension to right pleural cavity and metastasis to left lung. DUE TO (c) Kyphoscoliosis.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 25, 1967 , to April 26, 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 26, 1967 , and that death occurred at 8:45M , from causes and on the date stated above.							
22a. SIGNATURE 				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 26, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.				22d. ADDRESS 7620 York Rd., Towson, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/1/67		23c. NAME OF CEMETERY OR CREMATORY Balto. National Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR APR 27 1967		25b. REGISTRAR'S SIGNATURE 	

04203

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04808

CERTIFICATE OF DEATH

04808

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>30-4</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		d. STREET ADDRESS <u>1802 Eutaw Place</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>L.</u> Last <u>Malloy</u>		4. DATE OF DEATH Month <u>APRIL</u> Day <u>30</u> Year <u>19 67</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/15/96</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Joppa, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Robert Lomyer</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Herbert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-34-2669</u>	
17. INFORMANT <u>Mrs. Dorothy Harmeyer, 1300 Philadelphia Rd.</u>		Address <u>Joppa, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease & congestive heart failure</u> DUE TO <u>heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>heart failure</u> DUE TO <u>heart failure</u> (c) <u>heart failure</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30-4</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis; severe; decubitus ulcers</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-15</u> , 19 <u>67</u> to <u>4-30</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>67</u> and that death occurred at <u>10:35</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Charles Judge</u>		22b. DATE SIGNED <u>4-30-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANGELO JOPPA</u>		22d. ADDRESS <u>BCPH</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 2, 1967</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Trinity Lutheran Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Joppa Harford Md</u>	
24. FUNERAL DIRECTOR <u>Howard K. McComas & Son, Abingdon, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		25c. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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Baltimore County General 1803 Euton Place
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04803

CERTIFICATE OF DEATH

04809

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>				c. LENGTH OF STAY in 1b <u>1 DAY</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>GREATER BALTIMORE MEDICAL CENTER</u>				d. STREET ADDRESS <u>3333 N. CHARLES ST. 21218</u>			
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>E.</u> Last <u>MANSON</u>				4. DATE OF DEATH Month <u>4</u> Day <u>26</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-15-93</u>	9. AGE (In years last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SOCIAL SECURITY</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>THOMAS H. MANSON</u>				14. MOTHER'S MAIDEN NAME <u>SHOOT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>82-22-7319</u>		17. INFORMANT <u>PATIENT'S CHART</u> Address _____			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Aspiration pneumonia</u> <u>147X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Debilitation secondary to</u> DUE TO (c) <u>Cancer of hypopharynx</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>1 yr. 1 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-26</u> , 19 <u>67</u> , to <u>4-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-26</u> 19 <u>67</u> , and that death occurred at <u>4:30</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>V. R. BATOYON, M.D.</u>		22b. DATE SIGNED <u>4-27-67</u>		22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u>		22d. ADDRESS <u>6701 N. Charles St., Balto, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/29/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>GREENMOUNT</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. MEARS & SON 805 N. CALVERT ST.</u>				25a. REC'D BY REGISTRAR <u>MAY 2 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CERTIFICATE OF DEATH

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Center of Infection
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V. R. BATON
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W. R. BATON & SON, 205 E. CALLE ST., WYOMING

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04810

CERTIFICATE OF DEATH

04810

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parkville Md.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 8324 Beryl Rd.		d. STREET ADDRESS 8324 Beryl Rd.	
3. NAME OF DECEASED (Type or print) First Mary Middle A. Last Mansperger		4. DATE OF DEATH Month April Day 18 Year 19 67	
5. SEX F.M.	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1890
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months 03 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Baltimore County, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John Spielman	
14. MOTHER'S MAIDEN NAME Wilhelmina Jasper		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No	
16. SOCIAL SECURITY NO. 212-03-2535D		17. INFORMANT John A. Mansperger	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerosis DUE TO (c) Hypertensive cardiovascular Dis.		INTERVAL BETWEEN ONSET AND DEATH 10 days Indef. Indef.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from March , 1955, to 18 Apr , 1967, that (I) (we) last saw the deceased alive on 18 Apr , 1967, and that death occurred at 10:50 M , from causes and on the date stated above.			
22a. SIGNATURE Conrad Acton		22b. DATE SIGNED 18 Apr 67	
22c. PHYSICIAN'S NAME (Type) Conrad Acton		22d. ADDRESS 1208 St. Paul St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/22/67.	23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR APR 21 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04811		04811	
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 9 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 11 S. CAROLINE STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last MANUEL		4. DATE OF DEATH Month APRIL Day 2 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 8, 1891
9. AGE (In years lost birthday) yrs. 75		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RUFUS H. MANUEL		14. MOTHER'S MAIDEN NAME JENNIE JAMES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 217 05 09 39	
17. INFORMANT VA HOSPITAL		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA WITH EMPHYSEMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) OLD MYOCARDIAL INFARCTION (c) RIGHT ENCEPHALOMALACIA	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 24 , 19 67 , to APRIL 2 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 2 , 19 67 , and that death occurred at 115A M, from causes and on the date stated above.			
22a. SIGNATURE <i>Jorge A. Fabara</i>		22b. DATE SIGNED 4/3/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-6-67	
23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR <i>Way O. Wilson</i>		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>		25c. ADDRESS ORLEANS ST. BALTIMORE, MD.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04812

CERTIFICATE OF DEATH

04812

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 47 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mount de Sales Academy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Sister M. Helena Markert		4. DATE OF DEATH April 3, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 4, 1893
9. AGE (In years lost birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infirmarian (Religious) Mt. de Sales	
11. BIRTHPLACE (County & State, or foreign country) Baltimore City, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Adam Markert		14. MOTHER'S MAIDEN NAME Julia Doemling	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-54-3289	
17. INFORMANT Sister Francis de Sales		Address Md. 21228 700 Academy Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIOSCLEROTIC C.V. DISEASE DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January, 1967 , to April 3, 1967 , that (I) (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE Dario A. Ugarte M.D.		22b. DATE SIGNED 4/4/1967	
22c. PHYSICIAN'S NAME (Type) Dario A. Ugarte M.D.		22d. ADDRESS 5550 Baltimore Nat'l Pike Catonsville, Md. 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/5/1967	23c. NAME OF CEMETERY OR CREMATORY Mount de Sales Cemetery	23d. LOCATION (City or Town) (County) (State) Catonsville Baltimore Co. Md.
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR APR 6 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages (and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

58

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04813

04813

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 1727 Gorsuch Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Clara First V. Middle Martin Last		4. DATE OF DEATH Month April Day 23 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-6-94
9. AGE (In years last birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Brunswick, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John A. Dorr		14. MOTHER'S MAIDEN NAME Alice Hartley	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 219-12-535-	
17. INFORMANT Robert R. Butz		Address 5545 Gayland Rd. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Occlusion of the Right Coronary artery 4201 DUE TO Degenerated atherosclerotic plaque (b) DUE TO Atherosclerosis generalized severe. (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from April 10 , 19 67 , to April 23 , 19 67 that (we) last saw the deceased alive on April 23 , 19 67 , and that death occurred at 3:15 AM, from causes and on the date stated above.			
22a. SIGNATURE <i>Lawrence J. Misanik</i>		22b. DATE SIGNED April 23, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence J. Misanik, M.D.		22d. ADDRESS St. Joseph Hospital Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/26/67	23c. NAME OF CEMETERY OR CREMATORY Loudon Park	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Howard H. Hubbard		ADDRESS 4107 Wilkens Ave. 21229	
25a. REC'D BY REGISTRAR DATE: APR 27 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

04818

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04814

CERTIFICATE OF DEATH

04814

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY ---	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN lb 30.4	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 1514 E. 33rd St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BESSIE D. MASSEY		4. DATE OF DEATH April 25, 1967	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 31, 1882	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dr. Edwin G. Darling		14. MOTHER'S MAIDEN NAME Anna M. Brendel	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 213-03-1260	
17. INFORMANT Mrs. Florence M. Black-1 W. University Place		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Hypertension 443X DUE TO Heart Disease - Congestive Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Stroke pneumonia (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) prolonged stroke severe cerebral spine injury		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stroke sustained after fall down steps	
20c. TIME OF INJURY Month, Day, Year Hour a.m. May 1966 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore Md	
21. I certify that (I) (this hospital) attended the deceased from July 1, 1966 to April 25, 1967 , that (I) (we) last saw the deceased alive on April 24, 1967 , and that death occurred at 7:50 P.M. from causes and on the date stated above.			
22a. SIGNATURE Dr. Donald W. Mintzer		22b. DATE SIGNED 4/26/67	
22c. PHYSICIAN'S NAME (Type) Dr. Donald W. Mintzer		22d. ADDRESS 3009 Evergreen Ave., Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) entombment		23b. DATE THEREOF 4/27/67	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Baltimore, Md. --14		25a. REC'D BY REGISTRAR DATE APR 27 1967	
ADDRESS		25b. REGISTRAR'S SIGNATURE Charles Judge	

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Sept. 2, 1915

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
04816					04816				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)				
a. COUNTY		Baltimore			a. STATE		Md.		
		MARYLAND			b. COUNTY		Balto.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Owings Mills					Owings Mills 13.1				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
1 Samuel Road					1 Samuel Road				
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH				
Annie First Middle Last Maxwell					Month Day Year April 7, 19 67				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	
Female		White				Jan. 19, 1878		87	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?	
Housewife					Wisconsin			USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
Daved Woodruff					Mary Roach				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			215-48-2161		Mrs. Leona M. Lloyd Owings Mills, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Carcinoma of stomach								4 yrs	
151X DUE TO (b) Metastases to breast & lungs								2 yrs	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Cachexia								1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1-1-1932 to 4-7-1967, that (I) (we) last saw the deceased alive on 4-6-1967, and that death occurred at 2:45 P.M. from causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
James P. Saffell MD					M.D.			4-8-67	
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
James P. Saffell MD					Reisterstown Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		April 10, 67		Druid Ridge		Pikerville, Md.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
J. F. Eline & Sons Reisterstown, Md.					APR 10 1967		Charles Judge		

04816

STATE OF TEXAS

04816



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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04817

04817

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>			
c. LENGTH OF STAY IN 1b <u>60 yrs.</u>				d. STREET ADDRESS <u>Mt. Carmel Rd.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mt. Carmel Rd.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Walter Gilbert Mays</u>				4. DATE OF DEATH <u>APR. 18</u> 19 <u>67</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 22, 1906</u> <u>60</u> yrs.	
9. AGE (In years last birthday) <u>60</u>		IF UNDER 1 YEAR Months <u>18</u> Days <u>18</u>		IF UNDER 24 HRS. Hours <u>18</u> Min. <u>18</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Store</u>		11. BIRTHPLACE (State or foreign country) <u>Parkton, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>George Mays</u>				14. MOTHER'S MAIDEN NAME <u>Florence Bull</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>166-12-4397</u>		17. INFORMANT <u>Mrs. E. Pearl Mays, Parkton, Md. 21120.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Coronary occlusion</u> <u>4301</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>G. M. France</u>				22. DATE SIGNED <u>4/18/67</u>			
EXAMINER'S NAME (Type) <u>A. M. France</u>				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>April 21, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Carmel Cemetery</u>		23d. LOCATION (City, town or county) <u>Parkton, Md.</u> (State) _____	
24. FUNERAL DIRECTOR <u>Jacob Kortenstien, New Freedom, Pa.</u>				25a. REC'D BY REGISTRAR <u>APR 21 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Judge</u>	

TO DEPUTY MED. EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PV3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04818

CERTIFICATE OF DEATH

04818

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY xxxxxxx Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) xxxxxxx Glenburnie	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summitt Nursing Home		d. STREET ADDRESS 10 Greenwood Rd.	
3. NAME OF DECEASED (Type or print) MATHILDA MAZZA		4. DATE OF DEATH April 19, 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/14/69
9. AGE (In years last birthday) 98 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Italy		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christopher Mazza		14. MOTHER'S MAIDEN NAME Louisa Puzza	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Jean Shea		Address Glen Burnie, Md. 10 Greenwood Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221 DUE TO Chronic Congestive Heart Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO Arteriosclerotic Cardio Vascular Disease (c) DUE TO Generalized Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 14 years 15 years 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9/5/62 to 4/19/67 , that (I) (we) last saw the deceased alive on 4/18/67 19 67 , and that death occurred 755A M, from causes and on the date stated above.			
22a. SIGNATURE W.E. McGrath		22b. DATE SIGNED 4/20/67	
22c. PHYSICIAN'S NAME (Type) W.E. McGrath		22d. ADDRESS 1303 Frederick Rd. Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave.		25a. REC'D BY REGISTRAR APR 21 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04819

CERTIFICATE OF DEATH

04819

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN lb 13 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE (Jones Creek)		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 7350 GEISE AVENUE 21219		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle H. Last MC CLELLAN				4. DATE OF DEATH Month APRIL Day 12 Year 19 67			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCTOBER 21, 1886	
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) BENWOOD, WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INSPECTOR				10b. KIND OF BUSINESS OR INDUSTRY PIPE MILL		11. BIRTHPLACE (County & State, or foreign country) BENWOOD, WEST VIRGINIA	
13. FATHER'S NAME JOHN MC CLELLAN				14. MOTHER'S MAIDEN NAME MARGARET HADDOX			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213 07 47 32		17. INFORMANT CLIN RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. _____						INTERVAL BETWEEN ONSET AND DEATH 2 DAYS 14 YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PULMONARY INFARCTION. LOBAR PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from 3/31/67 , 19____, to 4/12/67 , 19____, that (X) (we) lost saw the deceased alive on 4/12/67 , 19____, and that death occurred at 3:50 PM , from causes and on the date stated above.							
22a. SIGNATURE <i>George Dudas</i>				22b. DATE SIGNED 4/12/67		22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND				22e. REC'D BY REGISTRAR APR 14 1967			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-15-1967		23c. NAME OF CEMETERY OR CREMATORY OAKLAWN CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR John J. Duda,				25a. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04820

CERTIFICATE OF DEATH

04820

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY in 1b 21206 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21206 d. STREET ADDRESS 7200 Willowdale Ave. 6 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Aubrey Vance McClINTOCK		4. DATE OF DEATH Month Day Year April 19, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 14, 1914
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welding Inspector		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	9. AGE (In years lost birthday) 52 yrs.
11. BIRTHPLACE (County & State, or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George W. McClintock		14. MOTHER'S MAIDEN NAME Minnie Heath	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 239-09-2959	
17. INFORMANT Mrs Ann M. McClintock		Address 7200 Willowdale Aven	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Colonic Ca with widespread Metastasis 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 31, 19 67 , to April 19, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 19, 19 67 , and that death occurred at 4 P.M. from causes and on the date stated above.			
22a. SIGNATURE Jaime Ambrad		22b. DATE SIGNED April 19 1967	
22c. PHYSICIAN'S NAME (Type) Jaime Ambrad		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-22-1967	23c. NAME OF CEMETERY OR CREMATORY Montlawn Cemetery	23d. LOCATION (City or Town) (County) (State) Raleigh N. Carolina
24. FUNERAL DIRECTOR Lassahn F. Home		25a. REC'D BY REGISTRAR APR 24 1967	
ADDRESS 7401 Belair Rd		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04821

04821

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b 21229 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore Co. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21229 d. STREET ADDRESS 907 Beechfield Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First James Middle M. Last McLAUGHLIN		4. DATE OF DEATH Month April Day 25 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 23, 1894
9. AGE (In years lost birthday) yrs. 72		10. IF UNDER 1 YEAR Months 72 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph G. McLaughlin		14. MOTHER'S MAIDEN NAME Marie Miller	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 215-18-5454		16. SOCIAL SECURITY NO. 215-18-5454	
17. INFORMANT M. Magdalen McLaughlin		Address 21229 907 Beechfield Ave	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Suppurative bronchopneumonia involving left lower lobe. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Post-operative left upper lobectomy. (c) Adenocarcinoma, left upper lobe.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I (this hospital) attended the deceased from April 1, 1967 , to April 25, 1967 , that I (we) last saw the deceased alive on April 25, 1967 , and that death occurred at 10:25M , from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik		22b. DATE SIGNED April 25, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/29/67	23c. NAME OF CEMETERY OR CREMATOR St. Peter's Cemetery	23d. LOCATION (City or Town) (County) (State) Queenstown Md.
24. FUNERAL DIRECTOR Howard H. Hubbard		25a. REC'D BY REGISTRAR APR 28 1967	
ADDRESS 4170 4107 Wilkens Ave.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04822

CERTIFICATE OF DEATH

04822

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 5 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 401 N. Curley Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MANUEL Middle LUTHER Last MC NEILL		4. DATE OF DEATH Month APRIL Day 16 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/14/18
9. AGE (In years last birthday) yrs. 48		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Marlinton, W.Va.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Arnot Mc Neill	
14. MOTHER'S MAIDEN NAME Ida Beverage		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II	
16. SOCIAL SECURITY NO. 232-22-54-69		17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 5810 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) HEPATIC COMA DUE TO (c) PORTAL CIRRHOSIS OF LIVER		INTERVAL BETWEEN ONSET AND DEATH RECENT RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour :m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 11 , 19 67 , to April 16 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 16 , 19 67 , and that death occurred at 7:35 PM from causes and on the date stated above.			
22a. SIGNATURE <i>Raul de Castro</i>		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) RAUL DE CASTRO, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL	23b. DATE THEREOF 4/21/67	23c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY	23d. LOCATION (City or Town) (County) (State) HAMPTON, VA.
24. FUNERAL DIRECTOR <i>Joseph N. Zannino Jr.</i>		25a. REC'D BY REGISTRAR JOSEPH N. ZANNINO FUNERAL HOME DATE APR 18 1967 257 S. CONKLING ST. BALTIMORE, MD.	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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1401 N. Carey Street

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04823 CERTIFICATE OF DEATH 04823											
1. PLACE OF DEATH a. COUNTY BALTIMORE, MD. GREATER BALTO. MEDICAL CENTER						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) MIDDLE RIVER					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson						c. LENGTH OF STAY IN lb 51 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTO. MEDICAL CENTER 6701 N. CHARLES ST.						d. STREET ADDRESS RT. 16, BOX 163 A					
3. NAME OF DECEASED (Type or print) HARRY ALFRED MENTZER						4. DATE OF DEATH APRIL 19 1967					
5. SEX MALE		6. COLOR OR RACE CAUCASIAN		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 12-5-08		9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRYER OPERATOR				10b. KIND OF BUSINESS OR INDUSTRY LEVER BROS. CO				11. BIRTHPLACE (County & State, or foreign country) ALTOONA, PENN.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY THOMAS MENTZER						14. MOTHER'S MAIDEN NAME MAGGIE M. YOUNG R.					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 170-12-1288		17. INFORMANT Ethel Menyzer Box 163A Bird River Rd. 20			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca Lung 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 2-26 - 1967 , to 4-19 1967 , that (I) (we) last saw the deceased alive on 4-19 - 1967 , and that death occurred at 10:55 AM from the causes and on the date stated above.											
22a. SIGNATURE RCHILLAR						M.D. ATTENDING PHYS. <input type="checkbox"/>			MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) RAM K. CHILLAR						22d. ADDRESS GRTR BALTO MED. CENTER BALTIMORE, MD. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith Cemetery				23d. LOCATION (City, town or county) (State) Baltimore Co., Md.	
24. FUNERAL DIRECTOR Bruzdzinski Funeral Home 1407 Eastern Ave.						25a. REC'D BY REGISTRAR APR 24 1967		25b. REGISTRAR'S SIGNATURE J Charles Judge			

MEDICAL CERTIFICATION

01333

01333

BALTIMORE, MD
GREATER BALTO MEDICAL CENTER
MAYLAND, 21220

61 DAYS
GREATER BALTO MEDICAL CENTER
6201 N. CHARLES ST.
ET. 16, BOX 13A

HARRY ALFRED WENTZER
MAY 19 1967
12-6-07

DRYER OPERATOR
HARRY THOMAS WENTZER
MAGGIE M. WENTZER
12-12-1968
School teacher box 1034 Bird River Rd. 20

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5-21 - 67
4-19 - 67
10:25AM

4-19 - 67
R. K. CHILLAS
R. K. CHILLAS

X
GREATER BALTO MEDICAL CENTER
BALTIMORE, MD 21220

Gardens of Faith Cemetery Baltimore Co., Md.

Funeral home 1407 Eastern Ave.

APR 21 1967

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04824

04824

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Longgreen c. LENGTH OF STAY IN b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Hyde Road - Long Green Pike			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Arm d. STREET ADDRESS Glen Arm Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last EIMER R. MILLER			4. DATE OF DEATH Month Day Year 4 4 1967		
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/29/23	9. AGE (In years last birthday) 43 ? yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Welder's Helper		10b. KIND OF BUSINESS OR INDUSTRY Factory		11. BIRTHPLACE (State or foreign country) md.	
13. FATHER'S NAME Leroy Miller			14. MOTHER'S MAIDEN NAME Mary Hall		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-14-7280	17. INFORMANT Edna Polston, Glenarm, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9298 Drowning DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Unknown - Found in creek			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 4 4 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Creek		20f. (City or town) (County) (State) Baltimore Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Werner U. Spitz, M.D. EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 4-4-67	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial	4/8/67	mt. joy		Mountjoy, Balt. Co. Md.	
24. FUNERAL DIRECTOR Wm. L. Chetman - 1701 M. Cullloch St. Balt. Md.		25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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UNITED STATES GOVERNMENT

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT

Items 18-21 Film 387 4-1 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04825

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04825

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson 03.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 820 Scarlett Drive		d. STREET ADDRESS 820 Scarlett Drive	
3. NAME OF DECEASED (Type or print) First J. Middle Wilbur Last MILLER		4. DATE OF DEATH Month April Day 8 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 1, 1886
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner		10b. KIND OF BUSINESS OR INDUSTRY Feed Supply	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Jacob Miller		14. MOTHER'S MAIDEN NAME L. Ellen Ernest	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-18-4169	
17. INFORMANT Mrs. Esther Miller, Same as # 2		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury to chest and abdomen 8359 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Arteriosclerotic cardiovascular disease		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Car fell off jack	
20c. TIME OF INJURY Month, Day, Year Hour 08 p.m. 4 8 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Towson Balto Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)	
22. DATE SIGNED 4/9/67			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1967	
23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Cemetery		23d. LOCATION (City or Town) (County) (State) Cockeysville, Maryland	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson, 1050 York Road Towson, Md. 21204		25a. REC'D BY REGISTRAR APR 12 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

04832

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APR 12 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item #2c & d Film #G388 1/26/67 pc

CERTIFICATE OF DEATH

Reg. Dist. No. 04826

04826

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE 21228				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21225			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Ridgeway Manor Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY KATHERINE MILLER				4. DATE OF DEATH April 16 19 67			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>		8. DATE OF BIRTH Sept. 25, 1881	
9. AGE (In years lost birthday) 85 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME James Turner				14. MOTHER'S MAIDEN NAME Katherine Nash			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 215-52-0067			
17. INFORMANT Mrs. Margaret Hoffman				Address 407 Arsan Ave. 21225			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) Generalized arteriosclerosis							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from January 1967 to April 16, 1967 , that I last saw the deceased alive on April 10, 1967 and that death occurred at 90 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Ricardo Lozada				ADDRESS (Street, city or town, state) 1725 S. Ches. St. Balto. Md.			
PHYSICIAN'S NAME (Type) RICARDO LOZADA M.D.				DATE SIGNED 4/17/67			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Apr. 19-67		22c. NAME OF CEMETERY OR CREMATORY Balto. National Cemetery		22d. LOCATION (City, town, or county) (State) Frederick Ave., Balto. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Flynn & Fleming				24a. REC'D BY REGISTRAR 1422 Light St.			
24b. REGISTRAR'S SIGNATURE APR 19 1967				DATE APR 19 1967			

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03810

CHICAGO, ILL.

03810

TO THE
HONORABLE
COMMISSIONER
OF THE
GENERAL LAND OFFICE
WASHINGTON, D. C.

SIR:

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above matter.

Very respectfully,
Yours truly,
[Signature]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. LENGTH OF STAY IN 1b D.O.A.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Balto. Co. General Hosp.		d. STREET ADDRESS 609 Leafydale Terrace	
3. NAME OF DECEASED (Type or print) First Morris Middle B. Last Miller		4. DATE OF DEATH Month April Day 1 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 7, 1929
9. AGE (In years last birthday) yrs. 37		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Claims examiner		10b. KIND OF BUSINESS OR INDUSTRY Soc. Sec.	
11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isadore Miller		14. MOTHER'S MAIDEN NAME Mildred Mitnick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 212-26-2096	
17. INFORMANT Mrs. Sue Ellen Miller, 609 Leafydale Terrace,		Address Balto. 8, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO 4301 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH. 5 min. est.	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples M.D.		22. DATE SIGNED 4-3-67	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		6 Hanover Rd., Randallstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-3-67	
23c. NAME OF CEMETERY OR CREMATORY Hebrew Friendship		23d. LOCATION (City or Town) (County) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Sol Levinson & Brow., Inc., 6010 Reist. Rd., Baltimore, Md.		25a. REC'D BY REGISTRAR APR 6 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>5 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>7003 Eastern Ave.,</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>Flora Miner</u>					4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7/15/1891</u>		9. AGE (In years last birthday) <u>75</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswf</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>a t home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>William Wilkens</u>	
14. MOTHER'S MAIDEN NAME <u>Matilda Hachtel</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>214-12-8695D</u>		17. INFORMANT <u>Mr. Roland Miner</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Emboli</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Myocardial Infarction</u> (a), stating the underlying cause last. DUE TO (c) <u>Aortic</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>2/13/62</u> 19 <u>to</u> <u>4/13</u> 19 <u>67</u> that (I) (we) last saw the deceased alive on <u>4/12</u> 19 <u>67</u> and that death occurred at <u>6:30 AM</u> from the causes and on the date stated above.	
22a. SIGNATURE <u>Robert J. Mahon</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/13/67</u>		
22c. PHYSICIAN'S NAME (Type) <u>Robert J. Mahon, M.D.</u>					22d. ADDRESS <u>204 E. Joppa Rd.,</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore Maryland</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Brooks Towson 1050 York Rd. 21204</u>					25. REC'D BY REGISTRAR <u>APR 17 1967</u> 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04825

04829

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY ANNE ARUNDEL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 14 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GLEN BURNIE		d. STREET ADDRESS 1213 KIMBERLY LANE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle BERNARD Last MONSEN		4. DATE OF DEATH Month APRIL Day 2 Year 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 6, 1891
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BRICK LAYER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
11. BIRTHPLACE (County & State, or foreign country) CHICAGO, ILLINOIS		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MORRIS MONSEN		14. MOTHER'S MAIDEN NAME ANNA ANDERSON	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 319 09 45 01	
17. INFORMANT VA HOSPITAL		18. CLINICAL RECORDS FORT HOWARD, MARYLAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 491X BRONCHOPNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. XXX METASTATIC CARCINOMA, RIBS, STERNUM AND CHEST WALL XXX DUE TO ARTERIOSCLEROTIC HEART DISEASE (c) UNKNOWN		INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from MARCH 19, 1967 , to APRIL 2, 1967 , that (1) (we) last saw the deceased alive on APRIL 2, 1967 , and that death occurred at 605P M, from causes and on the date stated above.			
22a. SIGNATURE Milton Ginsberg		22b. DATE SIGNED 4/3/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 4-7-67	
23c. NAME OF CEMETERY OR CREMATORY ACACIA CEMETERY		23d. LOCATION (City or Town) (County) (State) CHICAGO, ILLINOIS	
24. FUNERAL DIRECTOR HUBBARD FUNERAL HOME		25a. REC'D BY REGISTRAR APR 5 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		25c. DATE APR 5 1967	

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04830

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04830

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK				c. LENGTH OF STAY IN 1b 031			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 103 BALTIMORE AVE				d. STREET ADDRESS 103 BALTIMORE AVE			
3. NAME OF DECEASED (Type or print) First Middle Last MYRTLE MAE MORRIS				4. DATE OF DEATH Month Day Year APRIL 20 1967			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 12. 1908		9. AGE (In years last birthday) yrs. 58	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) AT HOME			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME JAMES K. SHIFLETT				14. MOTHER'S MAIDEN NAME MINNIE MORRIS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Address JOHN K. MORRIS 103 BALTIMORE AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Arterio-Sclerotic & Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CARDIO-VASCULAR DISEASE (c) ② Obesity							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ③ Thyroid-Pituitary Syndrome							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M. B. Davis M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) M. B. DAVIS M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) 6500 MORNINGTON			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR. 24. 1967		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION (City or Town) (County) (State) BALTIMORE CO MD	
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME-DUNDALK MD				25a. REC'D BY REGISTRAR DATE APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
				22. DATE SIGNED 4/25/67			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04831

04831

1. PLACE OF DEATH a. COUNTY Balto., MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Phoenix		c. LENGTH OF STAY IN 1b 2 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Box 265 Sweet Air Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HAROLD Middle W. Last MOYER		4. DATE OF DEATH Month APRIL Day 17 Year 19 67	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-6-1902
9. AGE (In years last birthday) 65 yrs.		10. IF UNDER 1 YEAR Months 17 Days 19 Hours 67 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pipefitter		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.	
11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Harvey Moyer		14. MOTHER'S MAIDEN NAME Dittwalked	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-03-5520	
17. INFORMANT Robert Moyer		Address Box 265 Sweet Air Rd.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Insufficiency with Angina Pectoris. (c) 1 Hour		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1965 to April 17, 1967 , that (I) (we) last saw the deceased alive on April 17, 1967 , and that death occurred at 9:08 A.M. from causes on and on the date stated above.			
22a. SIGNATURE Henry L. McCorkle M.D.		22b. DATE SIGNED April 19, 1967	
22c. PHYSICIAN'S NAME (Type) Henry L. McCorkle M.D.		22d. ADDRESS Jarrettsville Pike, Phoenix, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-67	
23c. NAME OF CEMETERY OR CREMATORY Parkwood Cem.		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home		25a. READ BY REGISTRAR APR 24 1967	
ADDRESS 7401 Belair Road		25b. REGISTRAR'S SIGNATURE [Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04832

CERTIFICATE OF DEATH

04832

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> <u>Greater Balto Med. Center</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Balto</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto.</u>		c. LENGTH OF STAY IN 1b <u>life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>2115 Gwynn Oak Ave. 21207</u>	
3. NAME OF DECEASED (Type or print) <u>Ruth Amelia Mullineaux</u>		4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/9/02</u>
9. AGE (In years last birthday) yrs. <u>65</u>		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Buyer</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>	
12. BIRTHPLACE (County & State, or foreign country) <u>Balto.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Richard William Mullineaux</u>		15. MOTHER'S MAIDEN NAME <u>Louisa Loos</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. <u>215-05-4592</u>	
18. INFORMANT <u>Admission sheet</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of (L) lung</u> <u>163X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>2-20</u> , 19 <u>67</u> , to <u>4/1</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31</u> , 19 <u>67</u> , and that death occurred at <u>12:50 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Derek A Bruce</u>		22b. DATE SIGNED <u>4/1/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEREK A. BRUCE</u>		22d. ADDRESS <u>G. B. M. C.</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/3/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Woodlawn, Maryland</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons</u>		25a. REC'D BY REGISTRAR DATE <u>APR 3 1967</u>	
ADDRESS <u>Narch & Penna Ave</u>		25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04833

CERTIFICATE OF DEATH

04833

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		c. LENGTH OF STAY in 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>103 Gothard Road--21093</u>		d. STREET ADDRESS <u>103 Gothard Road--21093</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>Musch</u>		4. DATE OF DEATH Month <u>April</u> Day <u>9</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-31-1891</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during usual of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Kestler</u>		14. MOTHER'S MAIDEN NAME <u>Catherine</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>2150333730</u>	
17. INFORMANT <u>Lester E. Musch</u>		Address <u>same</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATRIOSCELOTIC HEART DISEASE</u> <u>4200</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CHRONIC CONGESTIVE FAILURE</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>10-15 yrs</u> <u>10-15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>RENAL AZOTEMIA</u> <u>CARCINOMA BREAST (TREATED 1948)</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 19 <u> </u> , to <u>4/9</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>MARCH</u> 19 <u>67</u> , and that death occurred at <u>1 A</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>John H. Hebb</u>		22b. DATE SIGNED <u>4/9/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOHN A. HEBB</u>		22d. ADDRESS <u>812 PARK AVE -- 21201</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-11-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Baltimore, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. J...</u>			

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STATE OF TEXAS

APR 10 1963

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
04834					04834									
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)									
a. COUNTY BALTO					a. STATE MD									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON					b. COUNTY Baltimore									
c. LENGTH OF STAY IN 1b 11 DAYS					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DUNDALK									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOXLEIGH NURSING HOME					d. STREET ADDRESS 71 ADMIRAL BLVD.									
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print)			First CHESTER			Middle N.			Last MYERS					
4. DATE OF DEATH			Month 4			Day 9			Year 1967					
5. SEX MALE			6. COLOR OR RACE WHITE			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			8. DATE OF BIRTH 3-30-97					
9. AGE (In years last birthday) 70 yrs.			IF UNDER 1 YEAR			IF UNDER 24 HRS.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RAILROAD CONDUCTOR (RET)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Elmer E. Myers					14. MOTHER'S MAIDEN NAME Lilly Parthmore									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 195-07-0889					17. INFORMANT (Wife) Mrs. Esther Myers Address Md. 21222				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Arterio sclerosis DUE TO (c) unknown					INTERVAL BETWEEN ONSET AND DEATH 18 hours									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 3/29 , 19 67 , to 4/9 , 19 67 , that (I) (we) last saw the deceased alive on 4-8 , 19 67 , and that death occurred at 16:30 AM, from the causes and on the date stated above.														
22a. SIGNATURE David I Miller					22b. DATE SIGNED 4-9-67									
22c. PHYSICIAN'S NAME (Type) David I Miller					22d. ADDRESS Croison Rd Owings Mills, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 4/12/67			23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery			23d. LOCATION (City, town or county) (State) Baltimore, Md.					
24. FUNERAL DIRECTOR John J. Duda					ADDRESS 7922 Wise Ave. Dundalk, Md.					25a. REC'D BY REGISTRAR APR 12 1967				
										25b. REGISTRAR'S SIGNATURE J Charles Judge				

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DEPARTMENT OF HEALTH

APR 1 9 1967

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04835

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		e. STREET ADDRESS 4329 Newport Avenue	
3. NAME OF DECEASED (Type or print) First Rose Middle Lee Last MYERS		4. DATE OF DEATH Month 4 Day 27 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-15-49
9. AGE (In years last birthday) 18 yrs.		10. IF UNDER 1 YEAR Months 1 Days 1 Hours 1 Min. 1	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		12. KIND OF BUSINESS OR INDUSTRY none	
13. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		14. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. FATHER'S NAME Horace Lee Myers		16. MOTHER'S MAIDEN NAME Clara Mary Killander	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		18. SOCIAL SECURITY NO. none	
19. INFORMANT Rosewood Records, Owings Mills, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Septicemia DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Down's Syndrome, Severe Mental Retardation.			
19a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		19b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 8/3 , 1951, to 4/27 , 1967, that (X) (we) last saw the deceased alive on 4/27 , 1967, and that death occurred at 10:55 a.m. from causes and on the date stated above.			
22a. SIGNATURE <i>Zsolt Koppanyi</i>		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Zsolt Koppanyi, M.D.		22d. ADDRESS Rosewood St. Hosp., Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/1/67	23c. NAME OF CEMETERY OR CREMATORY Balto National	23d. LOCATION (City or Town) (County) (State) Frederick Rd, Md
24. FUNERAL DIRECTOR Austin E. Donovan - 3818 Roland Ave		25a. REC'D BY REGISTRAR MAY 1 1967	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04835

CERTIFICATE OF DEATH

04835

Name of Deceased		Date of Birth	
Sex		Race	
Place of Birth		Date of Death	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Date of Registration	

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED WAS
DECEASED ON THE DATE AND AT THE PLACE AND BY THE CAUSE
OF DEATH AS STATED IN THE FOREGOING CERTIFICATE OF DEATH
AND THAT THE DECEASED WAS AT THE TIME OF DEATH
A RESIDENT OF THE STATE OF CALIFORNIA.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04837

04837

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>101 Polinski Street</u>				e. STREET ADDRESS <u>111 Center Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Nelson</u> Last <u>Nelson</u>				4. DATE OF DEATH Month <u>4</u> Day <u>9</u> Year <u>1967</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>N.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-20-1898</u>	
9. AGE (in years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>3</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		12. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (State or foreign country) <u>Stafford Co., Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>UNK.</u>				14. MOTHER'S MAIDEN NAME <u>Ida Nelson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs. Florence Fleming</u>				Address <u>111 Center St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Failure</u> <u>5972</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Lung Disease</u> (c) <u>Hypertensive Cardiovascular Disease</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
22. ACTUAL SIGNATURE <u>Theo C Patterson</u>				23. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
24. EXAMINER'S NAME (Type) <u>THEO C PATTERSON</u>				25. M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
26. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				27. Address (Street, city, town, or county) <u>1701 Lauren St</u>			
28. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				29. DATE THEREOF <u>4-13-67</u>			
30. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cem.</u>				31. LOCATION (City, town or county) (State) <u>Baltimore Md.</u>			
32. FUNERAL DIRECTOR <u>Morton E Dyett F.H.</u>				33. ADDRESS <u>1701 Lauren St</u>			
34. REC'D BY REGISTRAR <u>APR 12 1967</u>				35. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00831

00831

11/11/54

11/11/54

11/11/54

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04838

04838

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>		c. LENGTH OF STAY IN 1b <u>404</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22, Md</u>		d. STREET ADDRESS <u>111 Center St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>111 Center St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Pearl Malinda Nelson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>18</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 3, 1900</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months <u>1</u> Days <u>18</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Stafford Co, Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Wesley Lee</u>		14. MOTHER'S MAIDEN NAME <u>Frances Thornton</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>51-014524</u>	
17. INFORMANT <u>Florence E. Fleming</u>		Address <u>111 Center St #22</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO <u>260x</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> (c) <u>64yr.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>March 1946</u> , to <u>April 18, 1967</u> that (I) (we) last saw the deceased alive on <u>April 18, 1967</u> , and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>William C. Wade</u>		22b. DATE SIGNED <u>4/18/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>William C. Wade M.D.</u>		22d. ADDRESS <u>140 Oak Ave Dundalk 22, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4-22-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Clevers Oak Ch. Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Frederickburg VA.</u>
24. FUNERAL DIRECTOR <u>Moeten & Dyett F.H.</u>		25a. REC'D BY REGISTRAR DATE <u>APR 19 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles J. Jones</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

88250

48825

[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "UNITED STATES" and "DEPARTMENT OF" are faintly visible.]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04839

CERTIFICATE OF DEATH

04839

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) o. STATE Maryland b. COUNTY Harford ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY in 1b 18yr8mth25dys	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS none	
3. NAME OF DECEASED (Type or print) First Martin Middle Neumeister Last Neumeister		4. DATE OF DEATH Month April Day 29 Year 19 67	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 14, 1897
9. AGE (In years lost birthday) yrs. 69		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY factory	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Henry Neumeister		14. MOTHER'S MAIDEN NAME Louise Nobelott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 214-03-2088	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bilateral pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from Aug. 4 , 19 48 to April 29 , 19 67 , that (he) (we) last saw the deceased alive on April 29 , 19 67 , and that death occurred at 10:00 M, from causes and on the date stated above.			
22a. SIGNATURE Stella Wachslar		22b. DATE SIGNED 5-1-67	
22c. PHYSICIAN'S NAME (Type) Stella Wachslar, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 5-5-67	23c. NAME OF CEMETERY OR CREMATORY MT. CARMEL CEM.	23d. LOCATION (City or Town) (County) (State) BALTO. MD
24. FUNERAL DIRECTOR John R. Miller - Montford & Jefferson		25a. REC'D BY REGISTRAR MAY 4 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01833

CERTIFICATE OF DEATH

1833

By virtue of the power conferred by the laws of the State of New York, I, the undersigned, do hereby certify that the following is a true and correct copy of the original record of the death of the person named herein.

NAME OF DECEASED: [illegible]

PLACE OF DEATH: [illegible]

DATE OF DEATH: [illegible]

AGE OF DECEASED: [illegible]

SEX OF DECEASED: [illegible]

CAUSE OF DEATH: [illegible]

DATE OF BURIAL: [illegible]

PLACE OF BURIAL: [illegible]

Attest: [illegible]

1833

1833

[Handwritten signatures and notes at the bottom of the page]

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04840

CERTIFICATE OF DEATH

04840

Item 2 Film G-307 4/11/67 KK

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) House-in-the-Pines - Catonsville		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville Baltimore d. STREET ADDRESS 3912 Milford Avenue 16 Rustling Avenue e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Nice Last Nice		4. DATE OF DEATH Month April Day 2 Year 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 2, 1878
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Watchman		10b. KIND OF BUSINESS OR INDUSTRY Distillery	9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ?		16. SOCIAL SECURITY NO. ?	
17. INFORMANT House in the Pines - Catonsville records		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasculum accident DUE TO appearing at side of body Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seriously			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from Jan 1967 to Apr 2, 1967 , that (I) (we) last saw the deceased alive on Apr 2, 1967 , and that death occurred at 10:00 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22a. SIGNATURE M Paul Byerly 22c. PHYSICIAN'S NAME (Type) M Paul Byerly		22d. ADDRESS 3420 York Rd Baltimore	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Zickman & Sons		25a. REC'D BY REGISTRAR Charles Judge 25b. REGISTRAR'S SIGNATURE Charles Judge	

REF. 1

132

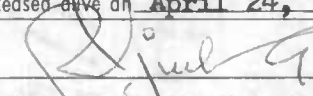

— 25 —

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04841

04841

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 15 30.4 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 3017 Woodhome Ave., #34 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles J NOHE		4. DATE OF DEATH Month Day Year April 24, 19 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 4, 1897
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinists		10b. KIND OF BUSINESS OR INDUSTRY contorl Co.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Jacobs Nohe		14. MOTHER'S MAIDEN NAME Mary Hierstetter	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 214-01-5311	
17. INFORMANT Loretta Nohe		Address Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Brain infarct 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO DUE TO DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that NO (this hospital) attended the deceased from April 20, 1967 , to April 24, 1967 , that we last saw the deceased alive on April 24, 1967 , and that death occurred at 8:40 M, from causes and on the date stated above.			
22a. SIGNATURE 		22b. DATE SIGNED April 24, 1967	
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-27-67	23c. NAME OF CEMETERY OR CREMATORY Parkwood	23d. LOCATION (City or Town) (County) (State) Baltimore Md.
24. FUNERAL DIRECTOR C.F. Evans & Son		25a. REC'D BY REGISTRAR DATE APR 27 1967	
ADDRESS 8802 Harford Road		25b. REGISTRAR'S SIGNATURE 	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

14841

14841

14841

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04842

CERTIFICATE OF DEATH

04842

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor, 509 E. Joppa Road		d. STREET ADDRESS 508 Chadwick Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Anna Middle Margaret Last Norris		4. DATE OF DEATH Month April Day 4 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1882
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At home		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry Froehlich		14. MOTHER'S MAIDEN NAME Roese	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT W. Landy Cook, 508 Chadwick Road.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF THE COLON 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3-13 , 19 67 , to 4-4 , 19 67 , that (I) (we) last saw the deceased alive on 4-3 , 19 67 and that death occurred at 11 P. M, from causes and on the date stated above.			
22a. SIGNATURE Luis J. Elias M.D.		22b. DATE SIGNED 4/6/67	
22c. PHYSICIAN'S NAME (Type) Luis J. Elias M.D.		22d. ADDRESS Northern Pkwy. & Loch Raven Blvd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/67	
23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) APR 10 1967 Charles Judge	
24. FUNERAL DIRECTOR Ullrich Funeral Home, Dundalk, Md.		25a. REC'D BY REGISTRAR APR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

04840

STATEMENT OF DEATH

1948

STATEMENT OF DEATH

NAME: [illegible]
AGE: [illegible]
SEX: [illegible]
DATE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF BIRTH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE: [illegible]
DATE: [illegible]

1948

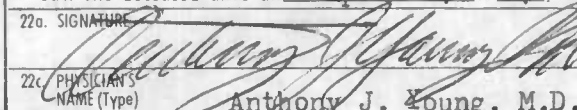
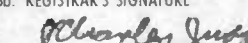
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04843

CERTIFICATE OF DEATH

04843

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Prince George's		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2yr5mth11dys	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hillcrest Heights, Md.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL			d. STREET ADDRESS 2412 Fairlawn Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Mamie Middle Obier Last Obier			4. DATE OF DEATH Month April Day 27 Year 19 67		
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1882	9. AGE (In years and birthday) 84 yrs.	IF UNDER 1 YEAR Months _____ Days _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY AT-HOME		11. BIRTHPLACE (County & State, or foreign country) Virginia	
13. FATHER'S NAME Taylor Clark			14. MOTHER'S MAIDEN NAME KING		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 230-12-3586		17. INFORMANT Address Records: Spring Grove State Hospital	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4341 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (A) (this hospital) attended the deceased from Nov. 16 , 19 64 , to April 27 , 19 67 , that (A) (we) last saw the deceased alive on April 27 , 19 67 , and that death occurred at 8:30 M, from causes and on the date stated above.					
22a. SIGNATURE 			MED. PHYS. <input type="checkbox"/> D. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED 4-8-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.			22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-29-1967	23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY	23d. LOCATION (City or Town) (County) (State) SUITLAND MD		
24. FUNERAL DIRECTOR W.W. Chambers Co 5801 Cleveland Ave Pwds			ADDRESS	25a. REC'D BY REGISTRAR MAY 1 1967	25b. REGISTRAR'S SIGNATURE 

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04844

04844

1. PLACE OF DEATH a. COUNTY <u>Baltimore County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General Hosp.</u>				d. STREET ADDRESS <u>5219 Windsor Mill Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marshall G Orndorff</u>				4. DATE OF DEATH Month <u>4</u> - Day <u>18</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-10-1899</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk A.A.R. Bureau</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B. & O. R.R.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>W. Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alexander Orndorff</u>				14. MOTHER'S MAIDEN NAME <u>Hannah Stickley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>Mrs. Arleen M. Orndorff 5219 Windsor Mill Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolism</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ischemic Heart Disease</u> DUE TO (c) <u>Congestive heart failure</u>							INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>10 yrs</u> <u>1 wk</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>—</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>3-30</u> , 19 <u>67</u> , to <u>4-18</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-18</u> , 19 <u>67</u> , and that death occurred at <u>9 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>de Jager</u>				22b. DATE SIGNED <u>4-18-67</u>		22c. PHYSICIAN'S NAME (Type) <u>de Jager</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-22-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Queens Point</u>		23d. LOCATION (City or Town) (County) (State) <u>Keyser, W.Va.</u>	
24. FUNERAL DIRECTOR <u>A. Howard Strong 3207 W. North Ave</u>				25a. REC'D BY REGISTRAR DATE <u>APR 20 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01810

1212

TECHNICAL DRAWING

Mr. J. J. O'Connell, 519 1/2

1-12-1962

U.S.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04845

04845

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			c. LENGTH OF STAY IN 1b <u>1 day</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferguson Rideewood</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med Center</u>				d. STREET ADDRESS <u>7827 Ruxwood Rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Hamilton</u> First Middle Last				4. DATE OF DEATH <u>April 21</u> 19 <u>67</u> Month Day Year			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>CAU</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>08-08-88</u>	
9. AGE (In years last birthday) <u>78</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED - EDITOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NEWSPAPER</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BALTIMORE, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>				13. FATHER'S NAME <u>Gwinn Fardon Owens</u>			
14. MOTHER'S MAIDEN NAME <u>UNKNOWN BELLE SMITH</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN NO</u>			
16. SOCIAL SECURITY NO. <u>213-03-2758</u>				17. INFORMANT <u>CHART. FAMILY</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Terminal Ca of Pancreas with</u> DUE TO (c) <u>Metastasis: Acute urinary retention</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Dr. Fr</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 20, 1967</u> , to <u>April 21, 1967</u> , that (I) (we) last saw the deceased alive on <u>4-20-67</u> , and that death occurred at <u>3:00 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Francisco L. Cootauco</u>				22b. DATE SIGNED <u>4/21/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. Francisco L. Cootauco</u>	
22d. ADDRESS <u>Greater Balto. Medical Center</u>				22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>4-24-67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co.</u>				25a. REC'D BY REGISTRAR <u>APR 24 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
ADDRESS <u>4905 York Rd. Balto., Md.</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04845

UNITED STATES OF AMERICA

04845

Mr. Francisco J. Geronzi, President, Banco de America, New York, New York

Mr. Geronzi

Mr. Geronzi

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FOR STATE HEALTH DEPT.
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04846

04846

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 623 Murdock Rd.				d. STREET ADDRESS 623 Murdock Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary Theresa Papania First Middle Last				4. DATE OF DEATH Month April Day 30 Year 1967			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 12, 1900	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) stenographer Balto.		10b. KIND OF BUSINESS OR INDUSTRY Cty Court H'se		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Pirrone				14. MOTHER'S MAIDEN NAME Caroline Vikirito			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-10-0556		17. INFORMANT Address Mrs. Adeline McCauley 6209 Leith Walk			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Hypertensive DUE TO (c) Cardio Renal Vascular Disease				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/30/67	
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 5/3/67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum Balto., Md.		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		ADDRESS 6500 York Rd. Balto., Md. 21212		25a. RECEIVED BY REGISTRAR MAY 3 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04847

CERTIFICATE OF DEATH

04847

1. PLACE OF DEATH a. COUNTY BALTO MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY BALTO ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRAY MANOR		c. LENGTH OF STAY IN 1b 304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 2810 Mc COMAS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GLADYS Middle PARADISE Last 4. DATE OF DEATH APRIL 16 1967		5. SEX F 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH 10-1-1901 9. AGE (In years last birthday) 65 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) KENTUCKY		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME DANIEL SPARKS		14. MOTHER'S MAIDEN NAME	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT MICHAEL PARADISE		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ca. of splenic flexum of colon c 1531 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec , 19 66 to 4/16 , 19 67 , that (I) (we) last saw the deceased alive on 4/13 , 19 67 , and that death occurred at 9P M, from causes and on the date stated above.			
22a. SIGNATURE Joseph R. Liberto		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) JOSEPH R. LIBERTO, M.D.		22d. ADDRESS 3508 BALTO ST - BALTIMORE, MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR. 19, 1967	
23c. NAME OF CEMETERY OR CREMATORY GREEK ORTHODOX		23d. LOCATION (City or Town) (County) (State) BALTO. MD.	
24. FUNERAL DIRECTOR J.E. CONNELLY SONS		25a. REC'D BY REGISTRAR APR 19 1967	
25b. REGISTRAR'S SIGNATURE Charles J. Juge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TABLE 10

13230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04848

CERTIFICATE OF DEATH

04848

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 11 Days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis		d. STREET ADDRESS 331 Bestgate Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle EDWARD Last PARKER		4. DATE OF DEATH Month APRIL Day 13 Year 1967	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/18/20
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months 46 Days 13 Hours 13 Min. 13	11. IF UNDER 24 HRS. Hours 13 Min. 13
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tractor Driver		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (County & State, or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Hollie Parker		14. MOTHER'S MAIDEN NAME Laura *Hye Hall	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW II		16. SOCIAL SECURITY NO. 214-11-04-95	
17. INFORMANT Clin. Rec. VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF UPPER ESOPHAGUS WITH METASTASIS 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (this hospital) attended the deceased from April 2 , 19 67 , to April 13 , 19 67 , that (we) last saw the deceased alive on April 13 , 19 67 , and that death occurred at 11:59PM from causes and on the date stated above.			
22a. SIGNATURE Milton Ginsberg		22b. DATE SIGNED 4/14/67	
22c. PHYSICIAN'S NAME (Type) MILTON GINSBERG, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 16-67	
23c. NAME OF CEMETERY OR CREMATORY Pinelawn Cemetery		23d. LOCATION (City or Town) (County) (State) Annapolis, Maryland	
24. FUNERAL DIRECTOR CHARLES HICKS FUNERAL HOME		25a. REC'D BY REGISTRAR APR 18 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

01818

RETURN OF DEATH

01818

Deceased: **James Earl Ray**
Date of Birth: **12/19/20**
Place of Birth: **St. Louis, Missouri**
Residence: **1000 1st St., St. Louis, Mo.**
Cause of Death: **Shot**
Place of Death: **St. Louis, Missouri**
Date of Death: **4/4/68**
Time of Death: **11:55 AM**
Sex: **M**
Age: **47**
Height: **5' 10"**
Weight: **175 lbs**
Color of Hair: **Black**
Color of Eyes: **Blue**
Color of Skin: **Fair**
Signature: **James Earl Ray**
Witness: **James Earl Ray**

Signature of Doctor: **James Earl Ray**
Signature of Coroner: **James Earl Ray**
Signature of Medical Examiner: **James Earl Ray**

Signature of Registrar: **James Earl Ray**
Signature of Clerk: **James Earl Ray**
Signature of Nurse: **James Earl Ray**
Signature of Embalmer: **James Earl Ray**
Signature of Undertaker: **James Earl Ray**
Signature of Funeral Home: **James Earl Ray**
Signature of Cemetery: **James Earl Ray**
Signature of Burial: **James Earl Ray**
Signature of Interment: **James Earl Ray**
Signature of Final Disposition: **James Earl Ray**

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04849

CERTIFICATE OF DEATH

04849

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>7108 Rogers Court 131</u>				d. STREET ADDRESS <u>7108 Rogers Court.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Medical Center.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JESSIE ELIZABETH Parkhurst</u>				4. DATE OF DEATH Month Day Year <u>April 17 1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>01-05-16</u>	9. AGE (In years lost birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME Baltimore</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>David McLean</u>				14. MOTHER'S MAIDEN NAME <u>FLORENCE E. MAC-NEAL unknown.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>unknown.</u>		17. INFORMANT <u>Pt. chart.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1950 Respiratory arrest</u> DUE TO (b) <u>Metastasis, Carcinoma of ovary</u> DUE TO (c) <u>7 mos. (7 mo)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <u>5 mins.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-17</u> , 19 <u>67</u> , to <u>4-17</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-17</u> 19 <u>67</u> , and that death occurred at <u>11:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>V.R. Batoyon</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>4-17-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. R. BATOYON</u>				22d. ADDRESS <u>67016 Charles St., Balto, Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		23d. LOCATION (City or Town) (County) (State) <u>Parkville, Balto. Co., Md.</u>	
24. FUNERAL DIRECTOR <u>H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>APR 18 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MDARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04850

04850

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		c. LENGTH OF STAY in 1b 7 WEEKS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CRISFIELD, MARYLAND			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL Center				d. STREET ADDRESS 118 MARYLAND AVE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle WILLIAM Last PARKS				4. DATE OF DEATH Month April Day 4 Year 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5-14-1906	9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WATCH MAN		10b. KIND OF BUSINESS OR INDUSTRY CARVEL HALL CUTLERY		11. BIRTHPLACE (County & State, or foreign country) CRISFIELD MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HARRY (NM) PARKS				14. MOTHER'S MAIDEN NAME MADRIX (DOLLIE MADRIX)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ADMISSION sheet		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Resp. Failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Bronchogenic carcinoma, with DUE TO (c) hepatic and cerebral metastases							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 2/13/1967 , to 4/4/1967 , that (H) (we) last saw the deceased alive on 4/4/1967 , and that death occurred at 7 P. M, from causes and on the date stated above.							
22a. SIGNATURE Dennis Chan				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/4/67	
22c. PHYSICIAN'S NAME (Type) DENIS CHAN M.D.				22d. ADDRESS GBMC			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APR 8, 1967		23c. NAME OF CEMETERY OR CREMATORY SUNNYRIDGE CEMETERY		23d. LOCATION (City or Town) (County) (State) CRISFIELD, MD	
24. FUNERAL DIRECTOR Bradshaw, Crisfield, Maryland				25a. REC'D BY REGISTRAR DATE APR 10 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

01850

CERTIFICATE OF DEATH

16870

[Faint, mostly illegible text and lines on a death certificate form. The form includes sections for personal information, cause of death, and medical history.]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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4

1

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04851

CERTIFICATE OF DEATH

04851

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		c. LENGTH OF STAY IN 1b <u>03.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph's Hospital</u>		d. STREET ADDRESS <u>204 E. Joppa Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Lutie</u> Middle <u>A.</u> Last <u>Parsons</u>		4. DATE OF DEATH Month <u>April</u> Day <u>5</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-30-1894</u>
9. AGE (In years last birthday) <u>72</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Gibson</u>		14. MOTHER'S MAIDEN NAME <u>Alice Blakley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-01-1467</u>	
17. INFORMANT <u>Leroy W. Dollinger</u>		Address: <u>Mt. Vista Rd. Bradshaw, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> DUE TO (b) <u>Arter. H. D.</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18</u> , 19 <u>65</u> , to <u>4/5</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>2/13</u> , 19 <u>67</u> , and that death occurred at <u>12:01 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>C. Edward Leach</u>		22b. DATE SIGNED <u>4/6/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>C EDWARD LEACH</u>		22d. ADDRESS <u>14 E. Eager St.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>4-8-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>	
24. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc Baltimore, Md.</u>		25. REC'D BY REGISTRAR <u>APR 7 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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10/1/51

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 10/1/51 BY 1043

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04852 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 04852

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Beth. Steel Hospital				d. STREET ADDRESS Sparrow Point Md. 031			
3. NAME OF DECEASED (Type or print) First Vernon Middle B. Last PARSONS				4. DATE OF DEATH Month APRIL Day 24 Year 1967			
5. SEX M.		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/4/20	
9. AGE (In years last birthday) 47 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel		11. BIRTHPLACE (State or foreign country) Virginia	
13. FATHER'S NAME John B. Parsons				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes W.W.II				16. SOCIAL SECURITY NO. 579-36-6505		17. INFORMANT Beatrice J. Parsons-8202 Peach Orchard Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Exogenous obesity				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theo C Patterson				22. DATE SIGNED 4/24/67			
EXAMINER'S NAME (Type) THEO C PATTERSON				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal		23b. DATE THEREOF 4/26/67		23c. NAME OF CEMETERY OR CREMATORY Parsons Family Cemetery		23d. LOCATION (City, town or county) (State) Pittsylvania Co.-Virginia	
24. FUNERAL DIRECTOR Robert C. Altenburg - 6009 Harford Rd. Funeral Home, Inc.				25a. REC'D BY REGISTRAR APR 26 1967			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04853

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04853

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>BALTIMORE</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WHITE HALL</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>White Hall, Md</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Grey Stone Rd.</u>				d. STREET ADDRESS <u>Hunters Mill Road</u>			
3. NAME OF DECEASED (Type or print) <u>William J. Partridge</u>				4. DATE OF DEATH <u>APR 16 1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 14, 1945</u>	
9. AGE (In years last birthday) <u>21</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electronic Repair</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Westinghouse</u>			
13. FATHER'S NAME <u>William T. Partridge</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Farksey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Viet Nam</u>				16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Elizabeth Partridge</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MULTIPLE TRAUMATIC INJURIES</u> <u>8514</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>STUCK A UTILITY POLE WHILE RIDING A MOTORCYCLE</u>			
20c. TIME OF INJURY Month, Day, Year <u>4/16 1967</u> Hour a.m. p.m. <u>8:30 p.m.</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>	
				20f. (City or town) <u>White Hall, Baltimore, Md</u>		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>A. M. France</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>A. M. FRANCE</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) <u>4/16/67</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Apr. 24, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		23d. LOCATION (City, town or county) (State) <u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Cook-Brooks Towson</u>				25a. REC'D BY REGISTRAR <u>Towson, Md 21204</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04854

04854

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jones Creek		c. LENGTH OF STAY IN 1b 21219		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 21219		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7300 Geise Ave.				d. STREET ADDRESS 7300 Geise Ave.			
3. NAME OF DECEASED (Type or print) First Charles Middle R. Last Patton				4. DATE OF DEATH Month April Day 26 Year 1967			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/12/20		9. AGE (In years last birthday) 46 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Helper on truck		10b. KIND OF BUSINESS OR INDUSTRY W. Kelly Gregory Inc.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Charles A. Patton				14. MOTHER'S MAIDEN NAME Freda Laubach			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-18-9324		17. INFORMANT (Mother) Mrs. Freda Reed		Address 7300 Geise Ave. Balto. Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion 4201 DUE TO HC VD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Exogenous obesity							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Theodore C. Patterson		M.D. M. D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 21222 4/28/67	
EXAMINER'S NAME (Type) Theodore C. Patterson		M. D. Address (Street, city, town, or county) 105 Main St. Dundalk		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/29/67		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Pk. Cem.		23d. LOCATION (City or Town) (County) (State) Liberty Road, Carroll Co. Md.	
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

04855

04855

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Towson				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Stella Maris Hospital				d. STREET ADDRESS 1601 East 25th Street			
3. NAME OF DECEASED (Type or print) First Isabelle Middle Wilson Last Perkins				4. DATE OF DEATH Month April Day 15 Year 1967			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 14, 1874	
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 13 Days 19		IF UNDER 24 HRS. Hours 15 Min. 67			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Missouri			
11. BIRTHPLACE (County & State, or foreign country) Missouri				12. CITIZEN OF WHAT COUNTRY? Missouri			
13. FATHER'S NAME Alexander Wilson				14. MOTHER'S MAIDEN NAME Isabelle Woods			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. 212-01-7149 D			
17. INFORMANT Mr. Arthur W. Perkins				Address 800 East Exchange St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Regenbry Arust 4221 DUE TO Coronary Heart Failure Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } (b) ASCD (c) ASCD							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-28-67 , 19 67 , to 4-15 , 19 67 , that (I) (we) last saw the deceased alive on 4/14 , 19 67 , and that death occurred at 11:40 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert J. Mithon				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Robert J. Mithon				22d. ADDRESS 204 C. Jappa Rd. Towson			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/17/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tichner				25a. RECORD REGISTRAR'S SIGNATURE APR 17 1967			

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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APR 11 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04856

CERTIFICATE OF DEATH

04856

1. PLACE OF DEATH a. COUNTY <u>Bolton County</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Bolton County</u> b. COUNTY <u>Md.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodlawn</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bolton County General Hosp.</u>		d. STREET ADDRESS <u>2108 Queensdale Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>Margaret</u> Middle <u>Elizabeth</u> Last <u>Hickson</u>		4. DATE OF DEATH Month <u>April</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/26/03</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u> Hours <u>17</u> Min.	11. IF UNDER 24 HRS. Months <u>6</u> Days <u>4</u> Hours <u>17</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William Fitcher</u>		14. MOTHER'S M maiden name <u>Bushman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220.30.0242</u>	
17. INFORMANT <u>Chait</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple embolism</u> 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CA of rony with metastasis</u> DUE TO (c) <u>Arteriosclerosis secondary to above</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1-7 hrs</u> <u>6-8 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-17, 1967</u> , to <u>4-17, 1967</u> , that (I) (we) last saw the deceased alive on <u>11-30-1967</u> , and that death occurred at <u>12:30 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Dr. Joyce</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>DEJOYA</u>		22d. ADDRESS <u>B.C.G. #1</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/20/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>J.T. Stansbury</u>		25a. BY REGISTRAR <u>APR 18 1967</u>	
ADDRESS <u>6411 Windsor Mill Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

04850

CERTIFICATE OF DEATH

04850

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04857

CERTIFICATE OF DEATH

04857

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write nearest town) Baltimore 28		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1216 Black Friars Rd.		d. STREET ADDRESS 1216 Black Friars Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First William Middle Pfaff Last		4. DATE OF DEATH Month APRIL Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31, 1880
9. AGE (In years last birthday) yrs. 86		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Pf aff		14. MOTHER'S MAIDEN NAME Katie	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 220-44-3489	
17. INFORMANT Mrs Joan Grelli		Address 1216 Black Friars Rd	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arterio-sclerotic Cardio Vasc. Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour "a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Oct 11, 1961 , to Apr. 14, 1967 , that (I) (we) last saw the deceased alive on Apr. 13, 1967 , and that death occurred at 3:07 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Harry L. Knipp		22b. DATE SIGNED 4-15-67	
22c. PHYSICIAN'S NAME (Type) Harry L. Knipp		22d. ADDRESS 4116 Edmondson Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 17, 67	23c. NAME OF CEMETERY OR CREMATORY Holy Cross	23d. LOCATION (City or Town) (County) (State) Ritchie Hwy. Glenburnie
24. FUNERAL DIRECTOR Witzke 4101 Edmondson Ave. Baltimore		25a. REC'D BY REGISTRAR APR 17 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04887

Bellevue
Bellevue

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1210 Black Prince Rd.

William

1911

Male

White

14

July 21, 1930

66

Married

Married

17 all

Katie

220-A-7889 The Town Grell 1210 Black Prince Rd

Harry L. Knapp

4110 Edmondson Ave.

April 17, 67 Holy Cross

Funeral

4110 Edmondson Ave. Baltimore

4110 Edmondson Ave. Baltimore

04887

Bellevue

Bellevue

Bellevue 21228

1210 Black Prince Rd.

04858

CERTIFICATE OF DEATH

04858

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 16 hrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital, Baltimore, Md. 21204		d. STREET ADDRESS 9442 Belair Road, 21206	
3. NAME OF DECEASED (Type or print) First DEBORAH Middle MARY MARIE Last POIST		4. DATE OF DEATH Month April Day 16 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 15, 1967
9. AGE (In years last birthday) 16		IF UNDER 1 YEAR Months 16 Days 16 Hours 16 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Baltimore		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Ralph Bernard Poist		14. MOTHER'S MAIDEN NAME Deborah Ann Schmidt	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Parents		Address same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure 773.5 DUE TO (b) (Cause of death determined) DUE TO (c) Immaturity of the lungs			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (X) (this hospital) attended the deceased from 4-15 , 19 67 to 4-16 , 19 67 , that (X) (we) lost saw the deceased alive on 4-16 , 19 67 , and that death occurred at 7:15 M, from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn M.D.		22b. DATE SIGNED 4-16-67	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Road, Baltimore, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF April 17, 1967	23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens	23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.		25a. REC'D BY REGISTRAR APR 24 1967	
		25b. REGISTRAR'S SIGNATURE J Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

048228

048228

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]
[The following text is extremely faint and largely illegible, appearing to be a standard memorandum format with fields for TO, FROM, SUBJECT, and a body of text.]

10-10-40
[The following text is extremely faint and largely illegible, appearing to be a continuation of the memorandum or a separate note.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04853 CERTIFICATE OF DEATH 04859

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 2mth 9dys	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 109 Wickham Road	
3. NAME OF DECEASED (Type or print) First Margaret Middle Katherine Last Pole		4. DATE OF DEATH Month April Day 8 Year 19 67	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 3, 1898
9a. AGE (In years last birthday) 69 yrs.		9b. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Spittel		14. MOTHER'S MAIDEN NAME Anna Steuben	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-01-4368	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTUS 1201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO (c) GENERAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH 17 days 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that HE (this hospital) attended the deceased from Jan. 13 , 19 67 , to Jan. 13 , 19 67 , that (I) (we) last saw the deceased alive on Jan. 13 , 19 67 , and that death occurred at 1:30 AM , from the causes and on the date stated above.			
22a. SIGNATURE Vicente M. Ruelas		22b. DATE SIGNED 4-8-67	
22c. PHYSICIAN'S NAME (Type) VICENTE M. RUASU		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-11-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue		25a. REC'D BY REGISTRAR 21229	
25b. REGISTRAR'S SIGNATURE Charles Judge		DATE APR 10 1967	

928-22

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04860

CERTIFICATE OF DEATH

04860

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garret</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>College Manor Nursing Home</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Elizabeth</u> ^{First} <u>Oflutt</u> ^{Middle} <u>Polk</u> ^{Last}				4. DATE OF DEATH Month <u>4</u> Day <u>16</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>August 20, 1886</u>		9. AGE (In years last birthday) yrs. <u>80</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>Daniel E. Oflutt</u>				
14. MOTHER'S MAIDEN NAME <u>Arabella Seymour</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>				
16. SOCIAL SECURITY NO. <u>220-48-4052</u>			17. INFORMANT <u>Family records</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO (b) <u>Cerebrovascular accident</u> DUE TO (c) <u>AS CLVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>Days</u> <u>Years</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Mar</u> , 19 <u>66</u> , to <u>May</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> 19 <u>67</u> , and that death occurred at <u>2 p</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>RK Gundry</u>			22b. DATE SIGNED <u>4-17-67</u>		22c. PHYSICIAN'S NAME (Type) <u>Richard K. Gundry, M.D.</u>		
22d. ADDRESS <u>2 West University, 21218</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal Burial April 18, 1967</u>		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Oakland, Maryland</u>	
24. FUNERAL DIRECTOR <u>John Burns' Sons, Towson, Maryland</u>			25a. REC'D BY REGISTRAR <u>APR 19 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

0022-0238

02810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04861

CERTIFICATE OF DEATH

04861

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md b. COUNTY <input checked="" type="checkbox"/>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 yr	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		30-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stella Maris Hospice		d. STREET ADDRESS 4301 Roland Ave.,	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) E. First Middle Last Fannie Pottgiesser		4. DATE OF DEATH 4 / 17 / 67 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 8/16/1880
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerical		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Baltimore Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Pottgiesser		14. MOTHER'S MAIDEN NAME Amanda Sweitzer	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-09-3195	
17. INFORMANT Hospice records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 578x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) G.I. Tract Bleeding, Cause Not Determined (c) Ascites			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 3/30/66 , 19__, to 4/17/67 , 19__, that (I) (we) last saw the deceased alive on 4/15/67 , 19__, and that death occurred at 6:01 PM , from causes and on the date stated above.			
22a. SIGNATURE Robert J. Mahon		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) Robert J. Mahon, M.D.		22d. ADDRESS 204 E. Joppa Rd.,	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF 4/21/67.	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, INC., Balto. Md.		25a. REC'D BY REGISTRAR APR 19 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

13881

13881

EXTRACT OF DEATH

WILLIAM STALL DEAN, JR. (DECEASED)
BORN AT NEW YORK, N.Y. 1850; DIED AT NEW YORK, N.Y. 1910

WILLIAM STALL DEAN, JR. (DECEASED)

WILLIAM STALL DEAN, JR.

WILLIAM STALL DEAN, JR.

WILLIAM STALL DEAN, JR.

WILLIAM STALL DEAN, JR.

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WILLIAM STALL DEAN, JR.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04862

CERTIFICATE OF DEATH

04862

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 031 21133</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Balto. Co. Gen. Hosp</u>		d. STREET ADDRESS <u>Box 361X Marriottsville Rd</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Calvin</u> Last <u>Powell</u>		4. DATE OF DEATH Month <u>4</u> Day <u>17</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-20-92</u>
9. AGE (In years last birthday) yrs. <u>75</u>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>lawn mower Rep</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James Powell</u>		14. MOTHER'S MAIDEN NAME <u>Martha DeVall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>217-12-8561</u>	
17. INFORMANT <u>Hosp. Record</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sibal bronchopneumonia</u> DUE TO (b) <u>Direct myocardium, thromboembolism</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>acute</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>4-4-1967</u> , to <u>4-17-1967</u> , that (I) (we) last saw the deceased alive on <u>4-17-1967</u> , and that death occurred at <u>2:30 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Edward L. Sherres, MD</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>17 Apr 67</u>
22c. PHYSICIAN'S NAME (Type) <u>Edward L. Sherres, MD</u>		22d. ADDRESS <u>Balto Co. Gen Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Pine Grove</u>	23d. LOCATION (City or Town) (County) (State) <u>Int Airy Carroll Md</u>
24. FUNERAL DIRECTOR <u>Loring Byers</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>

01885

OFFICE OF STATE

01885

STATE OF NEW YORK	
IN SENATE	
JANUARY 1, 1901	
REPORT	
OF THE	
COMMISSIONERS OF THE LAND OFFICE	
FOR THE YEAR 1900	
ALBANY:	
J. B. LIPPINCOTT & CO. PRINTERS	
1901	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04863

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore County	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 7038 Eastbrook Avenue		d. STREET ADDRESS 7038 Eastbrook Avenue	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WALTER Middle POWELL Last		4. DATE OF DEATH Month April Day 21 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 27, 1917
9. AGE (In years last birthday) 49 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Body & Fender Repair		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Walter Przybylowski		14. MOTHER'S MAIDEN NAME Michalina Ludwicki	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 216-01-3171	
17. INFORMANT Mrs. Margaret Powell		Address 7038 Eastbrook Avenue	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF ESOPHAGUS DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 8 MONTHS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/15/66 19, to 4/21/67 19, that (I) (we) last saw the deceased alive on 4/19/67 19, and that death occurred on 4/21/67 AM, from the causes and on the date stated above.			
22a. SIGNATURE Max Baum		22b. DATE SIGNED 4/22/67	
22c. PHYSICIAN'S NAME (Type) MAX BAUM		22d. ADDRESS 7422 EASTERN AVE - BALTO., MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-24-1967	
23c. NAME OF CEMETERY OR CREMATORY Holy Rosary		23d. LOCATION (City, town, or county) (State) Baltimore County, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Lilly & Zeiler Inc.		25a. REC'D BY REGISTRAR APR 24 1967	
ADDRESS 1901-07 Eastern Avenue		25b. REGISTRAR'S SIGNATURE Charles Judge	

04883

CERTIFICATE OF DEATH

04883

Residence

Residence

Baltimore County

1038 Lakeside Avenue

1038 Lakeside Avenue

POWELL

POWELL

Nov. 21, 1977

Nov. 21, 1977

Baltimore, Maryland

Body & Funeral Home

Michael J. Ludwig

United Presbyterian

215-61-1111 Mrs. Margaret Powell - 1038 Lakeside Avenue

No.

1038 Lakeside Avenue

1038 Lakeside Avenue

Baltimore County, Maryland

04864

CERTIFICATE OF DEATH

04864

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 21204	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Virginia Middle L. Last Priestas		4. DATE OF DEATH Month April Day 26 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-21-17
9. AGE (In years lost birthday) yrs. 49		10. IF UNDER 1 YEAR Months 03 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Cambridge, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William B. Burton		14. MOTHER'S MAIDEN NAME Mary M. Saulsbury	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 168-16-8294	
17. INFORMANT Mr. Edward Priestas		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bleeding esophageal varices. 5810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Advanced cirrhosis of the liver. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Cholecystectomy 10 days ago.			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 7 , 19 67 , to April 26 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 26 , 19 67 , and that death occurred at 12:15 AM from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn		22b. DATE SIGNED April 26, 1967.	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/29/67.	23c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR APR 27 1967	25b. REGISTRAR'S SIGNATURE Charles Jones

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ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 01-11-01 BY 60322
UCBAW/BJA

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04865

CERTIFICATE OF DEATH

04865

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1017 VANDERWOOD RD.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u> 03-1 d. STREET ADDRESS <u>1017 VANDERWOOD RD.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FRANCES H. PRZYBYLA</u>			4. DATE OF DEATH Month Day Year <u>APRIL 27 1967</u>				
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/27/10</u>	9. AGE (In years last birthday) <u>56</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MASS.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOSEPH MORTOWSKI</u>			14. MOTHER'S MAIDEN NAME <u>HELEN SKWISZ</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>JOHN A PRZYBYLA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Breast - Metastasis</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1964, to <u>4/27</u> , 1967, that (I) (we) last saw the deceased alive on <u>4/24</u> , 1967, and that death occurred at <u>4:30 PM</u> , from causes and on the date stated above.					
22a. SIGNATURE <u>James Nolan</u>			22b. DATE SIGNED <u>4/29/67</u>		22c. PHYSICIAN'S NAME (Type) <u>J S NOLAN</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>5/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LAKE VIEW</u>		
23d. LOCATION (City or Town) (County) (State) <u>CARROLL CO. MD.</u>			24. FUNERAL DIRECTOR ADDRESS <u>E.S. MACNABB 301 FREDERICK RD 21228</u>				
25a. REC'D BY REGISTRAR DATE <u>MAY 1 1967</u>			25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

04866

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04866

1. PLACE OF DEATH a. COUNTY Baltimore				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore				c. LENGTH OF STAY IN 1b 40 yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 6816 Duluth Avenue				e. STREET ADDRESS 6816 Duluth Avenue			
3. NAME OF DECEASED (Type or print) First Middle Last Alex J Puscian				4. DATE OF DEATH Month Day Year 4 22 197			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH II-7-1907	
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) Mississippi		12. CITIZEN OF WHAT COUNTRY? U.S.A	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sanitation Dept				10b. KIND OF BUSINESS OR INDUSTRY Baltimore County		11. BIRTHPLACE (State or foreign country) Mississippi	
13. FATHER'S NAME Felixx Puscian				14. MOTHER'S MAIDEN NAME A nna Olias			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 2I6-09-8000		17. INFORMANT Address Mrs Clara Puscian 6816 Duluth Avenue			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO (b) A-S-C-V-DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No one					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE M.B. Davis		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) M.B. Davis M.D. - Sunday		22. DATE SIGNED 4/22/67					
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-67		23c. NAME OF CEMETERY OR CREMATORY St Stanislaus Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR ADDRESS Walter Dabrowski 1005 Dundalk Avenue				25a. REC'D BY REGISTRAR APR 24 1967 DATE			
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04867

04867

FOR STATE
HEALTH DEPT.

M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tows on				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 2208 Wilker Ave.			
3. NAME OF DECEASED (Type or print) First Sophia Middle C. Last Quatman				4. DATE OF DEATH Month April Day 19 Year 1967			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/13/1875		9. AGE (In years last birthday) 91		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY AT Home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME HENRY HAMEL				14. MOTHER'S MAIDEN NAME Sophia			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT HENRY QUATMAN Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia and DUE TO (b) Bronchial Pneumonia DUE TO (c) Fracture Left Radius of Radius						INTERVAL BETWEEN ONSET AND DEATH 9 Days 13 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell down Bed Room					
20c. TIME OF INJURY Month/Day/Year Hour a.m. p.m. April 7 1967		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Baltimore	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles F. O'Donnell M.D.				22. DATE SIGNED 4/19/67			
EXAMINER'S NAME (Type) CHARLES F. O'DONNELL, M.D.				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-22-67		23c. NAME OF CEMETERY OR CREMATORY London Park		23d. LOCATION (City or town) (County) (State) BALTO. MARYLAND	
24. FUNERAL DIRECTOR C.F. Grawen				ADDRESS 8802 Norfolk Rd.		25a. REC'D BY REGISTRAR APR 21 1967	
				25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04868

04868

1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Baltimore</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Towson</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Chesapeake Manor Nursing Home</i>		d. STREET ADDRESS <i>1781 Joan Avenue</i>	
3. NAME OF DECEASED (Type or print) First <i>Elizabeth</i> Middle <i>Randall</i> Last <i>Randall</i>		4. DATE OF DEATH Month <i>April</i> Day <i>25</i> Year <i>1967</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/1/1903</i>
9. AGE (In years last birthday) <i>64</i> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John Terzano</i>		14. MOTHER'S MAIDEN NAME <i>Carmella Perella</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>219010154</i>	
17. INFORMANT <i>Mrs. Gloria Cullota</i>		Address <i>1626 Myamby Rd.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Arteriosclerosis, cerebral thrombosis</i> <i>332X</i> DUE TO <i>Arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Arteriosclerosis</i> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <i>2 1/2</i> <i>10 yrs</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>3 PM</i> , 19 <i>66</i> to <i>24 PM</i> , 19 <i>67</i> , that (I) (we) last saw the deceased alive on <i>24 PM</i> , 19 <i>67</i> , and that death occurred at <i>11 PM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>Leonard J. Ruck, Inc.</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <i>25 PM 1967</i>
22c. PHYSICIAN'S NAME (Type) <i>Leonard J. Ruck, Inc.</i>		22d. ADDRESS <i>6604 Baltimore Blvd. Balto. (34) Md</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>4/29/67</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>	23d. LOCATION (City or Town) (County) (State) <i>Baltimore, Maryland</i>
24. FUNERAL DIRECTOR <i>Leonard J. Ruck, Inc. Balto. Md. 21214</i>		25a. REC'D BY REGISTRAR DATE <i>APR 27 1967</i>	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

MEDICAL CERTIFICATION

04888

STATE OF TEXAS

02200

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THIS IS TO CERTIFY THAT THE ABOVE IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN THE OFFICE OF THE CLERK OF THE DISTRICT COURT OF THE COUNTY OF DALLAS, TEXAS, ON THE 10TH DAY OF MAY, 1900.

02200

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04863

CERTIFICATE OF DEATH

04869

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Randallstown				c. LENGTH OF STAY IN 1b 13-2			
d. NAME OF HOSPITAL OR INSTITUTION (If not a hospital, give street address) Baltimore County General Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Michele Margaret Reed				4. DATE OF DEATH Month Day Year April 8 19 67			
5. SEX F	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/17/61	9. AGE (In years last birthday) 6 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Balt. City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Conrad Reed				14. MOTHER'S MAIDEN NAME Brunhilde Katherina Stegmann			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mr. Richard C. Reed-Grooms Lane Woodstock Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Demerol 5101 DUE TO Intoxication & asphyxiation Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 1 day
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 770							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19 67 that (I) (we) last saw the deceased alive on _____ 19 67 , and that death occurred at 11:35 P.M. from causes and on the date stated above.							
22a. SIGNATURE Fred T. Kyper				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/10/67	
22c. PHYSICIAN'S NAME (Type) Dr. Fred T. Kyper				22d. ADDRESS 827 Park Ave. Balt., Md. 21201			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/12/67		23c. NAME OF CEMETERY OR CREMATORY Woodstock Cemetery		23d. LOCATION (City or Town) (County) (State) Woodstock, Md. Howard Co.	
24. FUNERAL DIRECTOR Loring Byers=8728 Liberty Rd. Randallstown				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04870

04870

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY CARROLL				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 5 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WESTMINSTER			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 108 E. GREEN STREET				
3. NAME OF DECEASED (Type or print) First Middle Last RALPH RODELL REESE				4. DATE OF DEATH Month Day Year APRIL 2 1967				
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUGUST 19, 1922		9. AGE (In years last birthday) 44 yrs.	10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PLUMBER		10b. KIND OF BUSINESS OR INDUSTRY PLUMBING SHOP		11. BIRTHPLACE (County & State, or foreign country) NEW WINDSOR, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME JAMES REESE				14. MOTHER'S MAIDEN NAME MARY C. SPOWE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) YES WW II		16. SOCIAL SECURITY NO. 213 18 86 09		17. INFORMANT Address CLINICAL RECORDS FORT HOWARD, MARYLAND				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) PORTAL CIRRHOSIS, LIVER WITH NECROSIS AND JAUNDICE UNKNOWN DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 28 , 1967, to APRIL 2 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 2 , 1967, and that death occurred at 1115PM , from causes and on the date stated above.								
22a. SIGNATURE <i>Peter V. Juvan</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/3/67		
22c. PHYSICIAN'S NAME (Type) PETER V. JUVAN, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND				
23a. BURIAL, CREMATION, RMDVAL (Specify) BURIAL		23b. DATE THEREOF 4/6/67	23c. NAME OF CEMETERY OR CREMATORY BENJAMIN'S REFORMED CHURCH CEM. WESTMINSTER, MD.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR <i>James C. Saffel</i>		ADDRESS SAFFEL FUNERAL HOME		25a. REC'D BY REGISTRAR APR 5 1967		25b. REGISTRAR'S SIGNATURE <i>John Charles Judge</i>		
MAIN STREET, WESTMINSTER, MD.								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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<div style="display: flex; justify-content: space-between;"> <div> <p>1</p> <p>04871</p> </div> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>04871</p> </div> </div>											
1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MD b. COUNTY Balto.					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GARRISON						c. LENGTH OF STAY IN 1b 21 DAYS					
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) FOXLEIGH NURSING HOME						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First DELLA Middle RENGEL Last RENGEL			4. DATE OF DEATH Month 4 Day 10 Year 1967			5. SEX FEMALE			6. COLOR OR RACE WHITE		
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 12/30/1899			9. AGE (In years last birthday) 67 yrs.			IF UNDER 1 YEAR Months 6 Days 10 Hours 19 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife						10b. KIND OF BUSINESS OR INDUSTRY Housewife					
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.						12. CITIZEN OF WHAT COUNTRY? U.S.A					
13. FATHER'S NAME Harry Easley						14. MOTHER'S MAIDEN NAME Anna Bennett					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (Yes, no, or unknown)						16. SOCIAL SECURITY NO. 213-01-4513					
17. INFORMANT Mrs Otilla Buchwald						Address 2913 Onyx Road #34					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Right Breast - metastasis 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH > 1 year											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.						20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)						20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 3-21 , 19 67 , to 4-10 , 19 67 , that (I) (we) last saw the deceased alive on 4-9 , 19 67 , and that death occurred at 7:45 PM , from the causes and on the date stated above.											
22a. SIGNATURE David I. Miller M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>										22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) David I. Miller										22d. ADDRESS Linson Rd. Owings Mills, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 4-13-1967		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery				23d. LOCATION (City, town or county) (State) Baltimore Md.	
24. FUNERAL DIRECTOR Lassahn Funeral Home 7401 Belair Road						25a. REC'D BY REGISTRAR APR 14 1967					
25b. REGISTRAR'S SIGNATURE Charles Judge											

1720

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04872

CERTIFICATE OF DEATH

04872

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE				c. LENGTH OF STAY IN IB 10 Days			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTO. MED CENTER				d. STREET ADDRESS Baltimore			
3. NAME OF DECEASED (Type or print) First SHIRLEY Middle ANN Last RICH				4. DATE OF DEATH Month APRIL Day 5 Year 1967			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1-7-1922		9. AGE (In years last birthday) 45	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SECRETARY		10b. KIND OF BUSINESS OR INDUSTRY OFFICE		11. BIRTHPLACE (County & State, or foreign country) BALTO. md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Richard Howard Bond				14. MOTHER'S MAIDEN NAME MARGARET FURLONG			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 217-18-3095		17. INFORMANT MRS CLYDE A. WILSON- (Pt's HISTORY) 4709 ROLAND AVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Ca. Ovary 1750 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) / DUE TO (c) /							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 3-27- , 1967, to 4/5/ , 1967, that (I) (we) last saw the deceased alive on 4/5/ , 1967, and that death occurred at 11:55PM , from causes and on the date stated above.							
22a. SIGNATURE Ram K. Chhillar				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/5/67	
22c. PHYSICIAN'S NAME (Type) RAM K. CHHILLAR				22d. ADDRESS GTR BALTO MED. CENTER BALTIMORE MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/7/1967	23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION (City or Town) (County) (State) Woodlawn, Balto. Co., Md.			
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co. 4905 York Rd. Balto. 12, Md.				25a. REC'D BY REGISTRAR APR 7 1967		25b. REGISTRAR'S SIGNATURE J Charles Jugh	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04873

CERTIFICATE OF DEATH

04873

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1317 Register Avenue		d. STREET ADDRESS 1317 Register Avenue	
3. NAME OF DECEASED (Type or print) First Carleton Middle E. Last Robinson		4. DATE OF DEATH Month April Day 20 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1893.
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months 73 Days 73 Hours 73 Min. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Teacher		10b. KIND OF BUSINESS OR INDUSTRY Maine	
11. BIRTHPLACE (County & State, or foreign country) Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Albert F. Robinson		14. MOTHER'S MAIDEN NAME Carrie E. Stevens	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 018-01-2440	
17. INFORMANT Mrs. Jennie M. Robinson		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial Infarction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular disease DUE TO (c) 10 years		INTERVAL BETWEEN ONSET AND DEATH 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypertensive Cardiovascular disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from September 1966 to 20 April 1967 , that (I) (we) last saw the deceased alive on 20 April 1967 , and that death occurred at 3 P. M. from causes and on the date stated above.			
22a. SIGNATURE Abraham Genevin		22b. DATE SIGNED 20 April 67	
22c. PHYSICIAN'S NAME (Type) ABRAHAM GENEVIN M.D.		22d. ADDRESS 611 PARK AVE BALTIMORE MD 21201	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE THEREOF 4/21/67.	
23c. NAME OF CEMETERY OR CREMATORY Greenmount Crematory		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214		25a. REC'D BY REGISTRAR DATE APR 24 1967	
25b. REGISTRAR'S SIGNATURE John J. Judge			

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04874

CERTIFICATE OF DEATH

04874

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS 4638 Marble Hall Rd.	
3. NAME OF DECEASED (Type or print) ISABELLE I. RODDY		4. DATE OF DEATH Month April , Day 7 , Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1882
9. AGE (In years last birthday) yrs. 84		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME (?) Fulton		14. MOTHER'S MAIDEN NAME Frances O'Brien	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) -		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs. A.F.O'Brien-706 Dunkirk Rd. 12		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (A) (this hospital) attended the deceased from March 31, 1967 to April 7, 1967 , that (B) (we) last saw the deceased alive on April 7, 1967 , and that death occurred at 2:36 P.M. from causes and on the date stated above.			
22a. SIGNATURE Regalado T. Dizon		22b. DATE SIGNED April 7, 1967	
22c. PHYSICIAN'S NAME (Type) Regalado T. Dizon M.D.		22d. ADDRESS 7620 York Rd. Towson Md. 21204	
23a. BURIAL, CREMATION, REMAINS (Specify)	23b. DATE THEREOF 4/10/67	23c. NAME OF CEMETERY OR CREMATORY CATHEDRAL CEM.	23d. LOCATION (City or Town) (County) (State) BALTO.
24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC. 6500 YORK ROAD, 21212		25a. REC'D BY REGISTRAR APR 10 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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1. The first part of the paper is devoted to the study of the asymptotic behavior of the solutions of the system (1) as $t \rightarrow \infty$. It is shown that the solutions of the system (1) tend to zero as $t \rightarrow \infty$ if and only if the matrix A is stable.

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11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04875

CERTIFICATE OF DEATH

04875

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>BALTO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		c. LENGTH OF STAY IN TB <u>2 yrs</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		d. STREET ADDRESS <u>2920 Niss Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>2920 Niss Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARTHA</u> Middle <u>M</u> Last <u>ROHNER</u>		4. DATE OF DEATH Month <u>Apr</u> Day <u>1</u> Year <u>1967</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 20 1902</u>
9. AGE (In years lost birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MINN</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DOMINIC WATERIN</u>		14. MOTHER'S MAIDEN NAME <u>ANNA THOMAS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>FAMILY RECORDS</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>2021</u> IMMEDIATE CAUSE (a) <u>Pulmonary Edema Congest Heart Failure</u> DUE TO (b) <u>Intermittent Cardio Vascular disease</u> DUE TO (c) <u>Generalized lymphomatosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>2 yrs</u> <u>5 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized debilitation precipitating #1 above</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not-While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>Apr</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>3/31/67</u> , and that death occurred at <u>10:45 PM</u> , from causes on and on the date stated above.			
22a. SIGNATURE <u>Frank T. Kasik Jr.</u>		22b. DATE SIGNED <u>4/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRANK T. KASIK JR.</u>		22d. ADDRESS <u>9005 HARFORD. Rd. BALTO MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4-5-67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD Cem.</u>		23d. LOCATION (City or town) (County) (State) <u>BALTO Co. MD</u>	
24. FUNERAL DIRECTOR <u>C. F. EVANS & SON</u>		25. REC'D BY REGISTRAR <u>APR 5 1967</u>	
25a. ADDRESS <u>8802 Harford Rd</u>		25b. REGISTRAR'S SIGNATURE <u>James J. Jones</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **04876**

04876

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rosedale.		c. LENGTH OF STAY IN lb 20 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-Rosedale.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 7934 Berk Lane			d. STREET ADDRESS 7934 Berk Lane		
3. NAME OF DECEASED (Type or print) Gertrude C. Rosenthal			4. DATE OF DEATH Month April Day 22 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-19-03		9. AGE (If years last birthday) 63 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Missouri, USA	
13. FATHER'S NAME Louis Bowman			14. MOTHER'S MAIDEN NAME Freida Storm		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Raymond E. Rosenthal 7934 Berk Lane.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) A-S-C-V-DISEASE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory street	
		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE M.B. Davis		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 4/22/67	
EXAMINER'S NAME (Type) M.B. Davis MD		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		Surgeon	
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		2111	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 4/25/67		22c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
				22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Lewis			24a. REC'D BY REGISTRAR APR 24 1967		
ADDRESS 1211 Chesebrough Ave			24b. REGISTRAR'S SIGNATURE Charles Judge		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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1. NAME OF DECEASED: [illegible]
2. SEX: [illegible]
3. AGE: [illegible]
4. DATE OF BIRTH: [illegible]
5. PLACE OF BIRTH: [illegible]
6. OCCUPATION: [illegible]
7. CAUSE OF DEATH: [illegible]
8. MANNER OF DEATH: [illegible]
9. SIGNATURE OF MEDICAL EXAMINER: [illegible]
10. DATE OF EXAMINATION: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 5-63

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>									
1. PLACE OF DEATH a. COUNTY <u>BALTIMORE COUNTY</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DULANEY-TOWSON NURSING HOME</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> g. STREET ADDRESS <u>4213 SPRINGDALE AVE</u>				
3. NAME OF DECEASED (Type or print) <u>ELFRIEDE</u>					4. DATE OF DEATH <u>ROSS</u> <u>APRIL 18</u> <u>1967</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 27, 1903</u>		9. AGE (In years last birthday) <u>63</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>GERMANY</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MR ERNEST ROSS</u>			Address <u>SAME</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Metastasis</u> <u>1531</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Carcinoma of the colon (hepatic flexure)</u> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH <u>sev. mos.</u> <u>sev. mos.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Art Sch. Heart disease</u>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a.m.</u> <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June</u> <u>1941</u> , to <u>April 18</u> , <u>1967</u> , that (I) (we) last saw the deceased alive on <u>April 18</u> , <u>1967</u> , and that death occurred at <u>4:45</u> <u>P.M.</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Louis V. Blum, M.D.</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>LOUIS V. BLUM, M.D.</u>					22d. ADDRESS <u>3502 W. Rogers Ave Balto Md 21215</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
<u>Burial</u>		<u>4/20/67</u>		<u>Har Sinai</u>		<u>Balto, Md</u>			
24 FUNERAL DIRECTOR'S SIGNATURE <u>Sylvan S. Lewis & Son, Inc</u>					ADDRESS <u>Garrison, Md</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>
DATE <u>APR 21 1967</u>									

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Ed. 10/12/1912

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

4

1

M

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04878

CERTIFICATE OF DEATH

04878

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21231		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 230 S. Ann St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle RUMINSKI Last RUMINSKI				4. DATE OF DEATH Month April Day 13 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/31/1888		9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months 79 Days 79 Hours 79 Min. 79	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Tailor		10b. KIND OF BUSINESS OR INDUSTRY Tailoring		11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Ruminski				14. MOTHER'S MAIDEN NAME Maryanna Kaczan			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-07-0963 A		17. INFORMANT Address St. Mrs. Bertha Zarachowicz, 321 S. Newkirk			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Osteo arthritis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 6 , 19 67 , to April 13 , 19 67 , that (I) (we) last saw the deceased alive on April 13 , 19 67 , and that death occurred at 2a M, from causes on and on the date stated above.							
22a. SIGNATURE Ramon P. Lopez				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 13, 1967	
22c. PHYSICIAN'S NAME (Type) Ramon P. Lopez M.D.				22d. ADDRESS 7620 York Rd. Towson 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/17/67		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR M.F. SADOWSKI & SONS, 1808 EASTERN AVE.				25a. REC'D BY REGISTRAR DATE APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04248

222

James P. Kelly

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04873

CERTIFICATE OF DEATH

04879

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 21133</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>8536 Liberty Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>Ra. Edwin</u> First <u>H. Russell</u> Middle <u>Lost</u>		4. DATE OF DEATH <u>4-8</u> Month <u>4</u> Day <u>8</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-28-05</u>
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>12</u> Min. <u>55</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		12. KIND OF BUSINESS OR INDUSTRY <u>Balt. Co. Md.</u>	
13. FATHER'S NAME <u>Edie Lynd Russell</u>		14. MOTHER'S MAIDEN NAME <u>Alice Arndt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>213-38-8285</u>	
17. INFORMANT <u>Mrs. Russell Sprague</u> Address <u>Randallstown</u>		18. <u>9739 Liberty Rd.</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension and Respiratory Depression</u> DUE TO <u>1401</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute myocardial Infarction</u> stating the underlying cause lost. (c) <u>ISCVD</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>12 hrs</u> <u>YEARS</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute leukemia & severe anemia</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>67</u> , to <u>4-8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-8</u> , 19 <u>67</u> , and that death occurred at <u>6:07</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Angelita T. Paul</u>		22b. DATE SIGNED <u>4-8-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANGELITA T. PAUL</u>		22d. ADDRESS <u>BC 211</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/12/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		23d. LOCATION (City or Town) (County) (State) <u>Pikesville, Md. 21208</u>	
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 12 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

04873

CERTIFICATE OF DEATH

04873

Name of Deceased		Date of Death	
Place of Birth		Date of Birth	
Cause of Death		Place of Death	
Signature of Physician		Signature of Registrar	
Date of Certificate		Place of Issuance	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH e. COUNTY <u>Baltimore</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u>					c. LENGTH OF STAY IN lb <u>4 yrs.</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Stella Maris Hospice</u>					d. STREET ADDRESS <u>1437 Kitmore Rd.</u>				
3. NAME OF DECEASED (Type or print) <u>Rosa P. Russo</u>					4. DATE OF DEATH <u>4/10/67</u>				
5. SEX <u>F</u>					6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					8. DATE OF BIRTH <u>11/1/1878</u>				
9. AGE (In years last birthday) <u>88</u>					10. IF UNDER 1 YEAR Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hvstf</u>					10b. KIND OF BUSINESS OR INDUSTRY				
11. BIRTHPLACE (County & State, or foreign country) <u>Sicily, Italy</u>					12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>Ignatius Papale</u>					14. MOTHER'S MAIDEN NAME <u>Emma (family name unknown- 1883)</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO. <u>None</u>				
17. INFORMANT <u>Hospice Records</u>					Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u>									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>ASCD</u>									
(c) <u>Diabetes mellitus</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. <u>19</u>									
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>									
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)									
21. I certify that (I) (this hospital) attended the deceased from <u>March 12, 1963</u> to <u>Apr. 10, 1967</u> , that (I) (we) last saw the deceased alive on <u>Apr. 10, 1967</u> , and that death occurred at <u>9:15 AM</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert J. Mahon</u> M.D.									
22b. DATE SIGNED <u>4/10/67</u>									
22c. PHYSICIAN'S NAME (Type) <u>ROBERT J. MAHON MD</u>									
22d. ADDRESS <u>204 E. Johns Rd. #14</u>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>									
23b. DATE THEREOF <u>4/12/67</u>									
23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cemetery</u>									
23d. LOCATION (City, town or county) (State) <u>Baltimore, Md.</u>									
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leonard J. Ruck, Inc. Balto. Md. 21214</u> ADDRESS									
25a. REC'D BY REGISTRAR <u>APR 11 1967</u> 25b. REGISTRAR'S SIGNATURE <u>Charles J. Judge</u>									

MEDICAL CERTIFICATION

008810

008810

008810

APR 11 1951

APR 11 1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04881

CERTIFICATE OF DEATH

04881

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville c. LENGTH OF STAY IN b 28 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 3309 Elgin Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First George Middle Sauer Last Sauer				4. DATE OF DEATH Month April Day 25 Year 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14, 1880	
9. AGE (In years last birthday) 86 yrs.		IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS. Hours 1 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Checker				10b. KIND OF BUSINESS OR INDUSTRY Arundel Corp.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME Justus Sauer				14. MOTHER'S MAIDEN NAME Katherine Menkel			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-20-9333		17. INFORMANT Address Mrs. Edna M. Steedman 552 Alleghany Ave.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Anterograde heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) 4200 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH 4 1/2 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/30 , 19 67 , to 4/25 , 19 67 , that (I) (we) last saw the deceased alive on 4/24 , 19 67 , and that death occurred at 10 A.M. , from the causes and on the date stated above.							
22a. SIGNATURE Robert A. Reiter				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/26/67	
22c. PHYSICIAN'S NAME (Type) Robert A. Reiter, M.D.				22d. ADDRESS 606 Edmondson Ave. 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-27-1967		23c. NAME OF CEMETERY OR CREMATORY New Cathedral		23d. LOCATION (City, town or county) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS G. Howard Strong 3207 W. North Ave.,				25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles J. Jones	

MEDICAL CERTIFICATION

1881

1881

No.

Bellevue

Bellevue

28 Ave

Bellevue

3000 Main Ave.

3000 Main Ave.

April 25

Save

Save

June 1, 1909

June 1, 1909

U. S. A.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md.

Bellevue, Md. 3000 Main Ave.

Bellevue, Md. 3000 Main Ave.

Bellevue, Md. 3000 Main Ave.

Bellevue, Md. 3000 Main Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04882

CERTIFICATE OF DEATH

04882

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN TB 46 DAYS	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		d. STREET ADDRESS 1332 MYRTLE AVENUE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First IRA Middle LEE Last SAVAGE		4. DATE OF DEATH Month APRIL Day 29 Year 1967	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 27, 1932
9. AGE (In years lost birthday) yrs. 35		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SEWELL SAVAGE		14. MOTHER'S MAIDEN NAME LULA DOWNING	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES PL-28		16. SOCIAL SECURITY NO. 229 39 47 03	
17. INFORMANT CLIN. REC., VAH, FORT HOWARD, MARYLAND		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RETICULUM CELL SARCOMA 2000 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH MONTHS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 14, 1967 to April 29, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 29, 1967 , and that death occurred at 10:00 a.m. from causes and on the date stated above.			
22a. SIGNATURE George Dudas		22b. DATE SIGNED 4 29 67	
22c. PHYSICIAN'S NAME (Type) GEORGE DUDAS, M. D.		22d. ADDRESS VAH, Ft. Howard, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 5/5/67	23c. NAME OF CEMETERY OR CREMATORY Church Cem	23d. LOCATION (City or Town) (County) (State) Accomac Co. Va.
24. FUNERAL DIRECTOR George A. Kelson		25. REGISTRAR'S SIGNATURE Charles Judge	
25a. REC'D BY REGISTRAR MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	
26. ADDRESS 1348 N. Calhoun Dr. Baltimore, Md.			

04885

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04883

CERTIFICATE OF DEATH

04883

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN b 19 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		d. STREET ADDRESS 315 INGLESIDE AVENUE	
3. NAME OF DECEASED (Type or print) First ANTHONY (KACZERGIBST) SCHAKUS, JR.		4. DATE OF DEATH Month APRIL Day 5 Year 19 67	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1892
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TAILOR		10b. KIND OF BUSINESS OR INDUSTRY TAILOR SHOP	
11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ANTHONY SCHAKUS Sr.		14. MOTHER'S MAIDEN NAME MARTHA MN: UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 216 01 63 21	
17. INFORMANT CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) THROMBOSIS RIGHT MIDDLE CEREBRAL ARTERY, ACUTE 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) THROMBOSIS LEFT MIDDLE CEREBRAL ARTERY, REMOTE DUE TO (c) CEREBRAL ARTERIOSCLEROSIS		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOSCLEROTIC HEART DISEASE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 3/17/67 , 19__ to 4/5/67 , 19__, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/5/67 , 19__, and that death occurred at 11:30 PM from causes and on the date stated above.			
22a. SIGNATURE Nielon Neilson		22b. DATE SIGNED 4/6/67	
22c. PHYSICIAN'S NAME (Type) NIELON NEILSON, M. D.		22d. ADDRESS VAH FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/8/67	
23c. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEMETERY		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR John J. Cowan & Son Inc.		25a. REC'D BY REGISTRAR JOHN J. COWAN & SON INC.	
25b. REGISTRAR'S SIGNATURE HOLLINS & POPPLETON		25c. DATE APR 7 1967	
25d. ADDRESS ST. BALTIMORE, MD.		25e. SIGNATURE Charles Judge	

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04884

CERTIFICATE OF DEATH

04884

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 65 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 03-1		d. STREET ADDRESS 700 Academy Road	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 700 Academy Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Katherine Veronica Schaub		4. DATE OF DEATH Month Apr. Day 14 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 2, 1879
9. AGE (In years last birthday) 88 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Nicholas Stumpf		14. MOTHER'S MAIDEN NAME Christina Rossman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 215-50-9184 T	
17. INFORMANT Mrs. Mary C. Schaub		Address Catonsville, Md. 21228 700 Academy Road	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MYOCARDIAL INFARCTION DUE TO H201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CHRONIC SEVERE CORONARY - ARTERIO-SCLEROSIS DUE TO DISEASE (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 66 , to 4/14 , 19 67 , that (I) (we) last saw the deceased alive on 4/14 , 19 67 , and that death occurred at 5:45 PM , from causes and on the date stated above.			
22a. SIGNATURE John H. Shaw		22b. DATE SIGNED 4/17/67	
22c. PHYSICIAN'S NAME (Type) John H. Shaw M.D.		22d. ADDRESS 5800 Edmondson Ave. Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 17, 1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Baltimore, Md.
24. FUNERAL DIRECTOR Catonsville Funeral Home		25a. REC'D BY REGISTRAR DATE APR 18 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04885

CERTIFICATE OF DEATH

04885

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville			c. LENGTH OF STAY IN 1b 20yr3mth24dys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 3606 Lucille Avenue #15		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Esther Middle Schilansky Last Schilansky				4. DATE OF DEATH Month April Day 17 Year 19 67					
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH XXXXXXXXXXXX NEED 77			
9. AGE (In years last birthday) 77		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —					
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) housewife			10b. KIND OF BUSINESS OR INDUSTRY At Home		11. BIRTHPLACE (County & State, or foreign country) Poland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Jake Cohen				14. MOTHER'S MAIDEN NAME XXXXXXXX ANNA ?					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218-22-1035A		17. INFORMANT Records: SPRING GROVE STATE HOSPITAL			Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4330 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumonia DUE TO (c) Generalized arteriosclerosis							INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. —			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that it (this hospital) attended the deceased from Dec. 23 , 19 46 , to April 17 , 19 67 that (I) (we) last saw the deceased alive on April 17 , 19 67 , and that death occurred at 4:05 M, from causes and on the date stated above.									
22a. SIGNATURE <i>Evelio A. Felipe</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED 4-17-67	
22c. PHYSICIAN'S NAME (Type) Evelio A. Felipe, M.D.				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/67		23c. NAME OF CEMETERY OR CREMATORY Bir Chayim		23d. LOCATION (City or Town) (County) (State) Cumberland Md.			
24. FUNERAL DIRECTOR Sol Levinson				ADDRESS 6 Bros. In c., 6010 Reisterstown		25a. REC'D BY REGISTRAR APR 21 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04886

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN b <u>1 day</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Balto. Med. Center</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Carney</u> 03-1 d. STREET ADDRESS <u>10110 Fontaine Drive</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Schriefer Betty</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>			4. DATE OF DEATH Month <u>4</u> Day <u>5</u> Year <u>1967</u> 8. DATE OF BIRTH <u>9-9-28</u> 9. AGE (In years last birthday) <u>38</u> yrs. 11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				
13. FATHER'S NAME <u>John Kotch</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u> 16. SOCIAL SECURITY NO. <u>220-22-4409</u>			14. MOTHER'S MAIDEN NAME <u>Florence Lewis</u> 17. INFORMANT (Husband) <u>John A. Schriefer, 10110 Fontaine Dr.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio - Resp. Failure</u> 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of Breast,</u> DUE TO (c) <u>Pulmonary metastasis</u>					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>4/4/1967</u> to <u>4/5/1967</u> that (I) (we) last saw the deceased alive on <u>4/5/1967</u> , and that death occurred at <u>5:30 A.M.</u> from causes and on the date stated above.					
22a. SIGNATURE <u>Dennis Chan</u>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED <u>4/5/67</u>		22c. PHYSICIAN'S NAME (Type) <u>DENIS CHAN M.D.</u> 22d. ADDRESS <u>GB MC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/8/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cemetery</u>			
23d. LOCATION (City or Town) (County) (State) <u>Baltimore, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>John J. Duda 7922 Wise Ave. Dundalk, Md.</u>					
25a. REC'D BY REGISTRAR DATE <u>APR 10 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J Charles Judge</u>					

01886

CERTIFICATE OF DEATH

01886

TO WHOM IT MAY CONCERN

I, the undersigned, being a duly qualified Medical Officer of Health for the City and County of New York, do hereby certify that

the within and foregoing is a true and correct copy of the original as the same appears in the records of the Department of Health of the City and County of New York.

Witness my hand and the seal of the Department of Health of the City and County of New York, this 10th day of April, 1907.

JOHN J. WATSON, M.D.,
Medical Officer of Health.

APR 10 1907

1907 MAR 11 - 11:00 AM

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04887

CERTIFICATE OF DEATH

04887

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 1 yr. 3 mos.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson/ Baltimore		304	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Chesapeake Manor Nursing Home		d. STREET ADDRESS 508 E. Toppa Road 693 Gladstone	
3. NAME OF DECEASED (Type or print) EMMA T. SCHULTZE		4. DATE OF DEATH Month April Day 8 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1875
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Otto Tuerke		14. MOTHER'S MAIDEN NAME Elizabeth Festman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-01-2572	
17. INFORMANT Mr. Alvin E. Schultze, Flushing, New York		Address 138-10 Franklin Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive C-V Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 15 hours 15 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from January 1950 , to April 8, 1967 , that (I) (was) last saw the deceased alive on April 8, 1967 , and that death occurred at 11:00 M, from causes and on the date stated above.			
22a. SIGNATURE A. Allan Spier		22b. DATE SIGNED 4/9/67	
22c. PHYSICIAN'S NAME (Type) A. Allan Spier, M.D.		22d. ADDRESS 1501 Pentridge Rd., Baltimore, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Apr. 11, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson,		25a. REC'D BY REGISTRAR APR 11 1967	
1050 York Road Towson, Md. 21204		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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STATEMENT OF DEBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
20 M 1/66

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MDARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
04888 Item #2b,c & d Film #G388 4/25/67 pc 04888

1. PLACE OF DEATH a. COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Ind.</u> b. COUNTY <u>Salisbury Wic.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY IN 1b <u>Since 1962.</u>		d. STREET ADDRESS <u>427 Granby Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Maryland Masonic Homes</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUISE L. SCHWARTZ</u>		4. DATE OF DEATH Month Day Year <u>4 13 1967</u>	
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 29th 1902.</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Council Bluffs Iowa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John W. Lawman.</u>		14. MOTHER'S MAIDEN NAME <u>Blaiche Robey.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-16-7336</u>	
17. INFORMANT <u>Maryland Masonic Home Pockysville</u>		Address <u>Ind.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> DUE TO (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>Ventricular stand still</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1967</u> , to <u>April 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1967</u> , and that death occurred at <u>9:30 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Jamshid Hamed MD.</u>		22b. DATE SIGNED <u>4/13/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMSHID HAMED MD.</u>		22d. ADDRESS <u>COCKEYSVILLE</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Apr. 17, 1967</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>		23d. LOCATION (City or Town) (County) (State) <u>Princess Anne Ind.</u>	
24. FUNERAL DIRECTOR <u>Wm. C. Brooks Towson</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 17 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04889

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04889

1. PLACE OF DEATH a. COUNTY Baltimore		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN lb 1mth17dys	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS 2812 Dunlaw Court	
3. NAME OF DECEASED (Type or print) Amelia		4. DATE OF DEATH Month April Day 27 Year 1967	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1898
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) 68 yrs.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME James T. Lawrence		14. MOTHER'S MAIÖEN NAME Amelia T.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Records: SPRING GROVE STATE HOSPITAL		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary emboli 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 72 hrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that no (this hospital) attended the deceased from March 10, 1967 to April 27, 1967 , that we (we) last saw the deceased alive on April 27, 1967 , and that death occurred at 1:10 M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Anthony J. Young</i>		22b. DATE SIGNED 4-27-67	
22c. PHYSICIAN'S NAME (Type) Anthony J. Young, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 5/1/1967	
23c. NAME OF CEMETERY OR CREMATORY PARKWOOD		23d. LOCATION (City, town or county) (State) BALTO. CO. Md	
24. FUNERAL DIRECTOR W. Burt Bradley, Dundalk, Md		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04890

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04890

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glyndon	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Greater Baltimore Medical Center				d. STREET ADDRESS Pennington Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First WILLIAM Middle E. Last SEWARD				4. DATE OF DEATH Month April Day 7 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 4, 1894		9. AGE (In years lost birthday) 73 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired From State Roads			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Balto. Co. Md.		12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME Thomas W. Seward				14. MOTHER'S MAIDEN NAME Jane E. Baublitz			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-03-2779		17. INFORMANT Mrs. Maxine Seward Glyndon, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease. 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Hour a.m. Month, Day, Year p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Naturol causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Charles S. Petty EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)		22. DATE SIGNED 4/8/67	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF April 11, 67		23c. NAME OF CEMETERY OR CREMATORY Grace Cemetery		23d. LOCATION (City or Town) (County) (State) Butler Md.	
24. FUNERAL DIRECTOR J. F. Eline & Sons Reisterstown, Md.				25a. REC'D BY REGISTRAR APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles Jones	

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APR 11 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04891

CERTIFICATE OF DEATH

04891

1. PLACE OF DEATH BALTIMORE a. COUNTY Catonsville MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) ✓ a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 49yr9mth29dys	
d. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital, give street address) SPRING GROVE STATE HOSPITAL		d. STREET ADDRESS unknown	
3. NAME OF DECEASED (Type or print) First Philip Middle Shevcha Last 4. DATE OF DEATH Month April Day 19 Year 1967		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1882
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Unknown		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO. 219-54-3423		17. INFORMANT Address Records: SPRING GROVE STATE HOSPITAL	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized and severe DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that he (this hospital) attended the deceased from June 20, 1917 to April 19, 1967 , that (I) (we) last saw the deceased alive on April 19, 1967 , and that death occurred at 10:30 AM , from causes and on the date stated above.			
22a. SIGNATURE Morris Meiller M.D.		22b. DATE SIGNED 4/19/67	
22c. PHYSICIAN'S NAME (Type) MORRIS MEILLER, M.D.		22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228	
23a. BURIAL, CREMATION, OR MOVAL (Specify) Burial	23b. DATE THEREOF April 21-1967	23c. NAME OF CEMETERY OR CREMATORY New Cathedral	23d. LOCATION (City or Town) (County) (State) Old Frederick Rd. Baltimore Md
24. FUNERAL DIRECTOR Krause Funeral Home 1216 S Charles St #2230		25a. REC'D BY REGISTRAR DATE APR 24 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04892

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04892

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md.</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City, Md. 21043</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>21043 RIVER ROAD</u>				d. STREET ADDRESS <u>River Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Albert</u> Last <u>Shipley</u>				4. DATE OF DEATH Month <u>April</u> Day <u>24</u> Year <u>1967</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/30/10</u>		9. AGE (In years last birthday) <u>56</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Flour Mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>D.C.A.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Albert Shipley</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Dntell</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-09-6145</u>		17. INFORMANT <u>Marion Shipley, Main St. Ellicott City, Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cirrhosis Liver.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>James N. Frederick</u> M.D. EXAMINER'S NAME (Type) <u>James N. Frederick md</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>1311 Francis Ave Balto. Md. 21222</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-28-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		23d. LOCATION (City or Town) (County) (State) <u>Ellicott City, Md</u>	
24. FUNERAL DIRECTOR <u>F.C. Higginbotham</u> ADDRESS <u>Ellicott City, Md</u>				25a. REC'D BY REGISTRAR <u>APR 27 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04893

CERTIFICATE OF DEATH

04893

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Balto.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Reisterstown</u>		c. LENGTH OF STAY IN 1b <u>421</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>37 Hanover Road</u>		d. STREET ADDRESS <u>37 Hanover Road</u>	
3. NAME OF DECEASED (Type or print) First <u>Frank</u> Middle <u>Shugars</u> Last <u>Shugars</u>		4. DATE OF DEATH Month <u>April</u> Day <u>13</u> Year <u>19 67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 1, 1880</u>
9. AGE (In years last birthday) <u>86</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Balto. Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>George Shugars</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mr. Frank M. Shugars</u>		Address <u>Reisterstown, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO <u> </u> (c) <u>with cardiac decompensation</u> <u>Chronic Brain syndrome</u>			INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hrs.</u> <u>years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Duodenal ulcer</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 5</u> , 19 <u>57</u> , to <u>Apr. 13</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>Apr. 12</u> 19 <u>67</u> , and that death occurred at <u>4A.</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Martin E. Strobel</u>		22b. DATE SIGNED <u>4-13-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Martin E. Strobel, M.D.</u>		22d. ADDRESS <u>48 Main St. Reisterstown, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>April 15, 67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>All Saints Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Reisterstown, Md.</u>
24. FUNERAL DIRECTOR <u>J. F. Eline & Sons</u>		25. REC'D BY REGISTRAR <u>APR 17 1967</u>	
ADDRESS <u>Reisterstown, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

01833

RECEIVED OF DEATH

01833

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04894

CERTIFICATE OF DEATH

04894

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY 30-1	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard		c. LENGTH OF STAY IN 1b 70 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore - 17		d. STREET ADDRESS 1432 McCulloh Street	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON * - - - - SIMON		4. DATE OF DEATH Month Day Year April 21 1967	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/20
9. AGE (In years last birthday) 46		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Steel	
11. BIRTHPLACE (County & State, or foreign country) Bishopville, S.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tom Simon		14. MOTHER'S MAIDEN NAME Mamie Hainesworth	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWII		16. SOCIAL SECURITY NO. 247 14 17 23	
17. INFORMANT Clinical Rcds. VA Hospital, Fort Howard, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHOPNEUMONIA 002.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) PULMONARY TUBERCULOSIS DUE TO (c) TUBERCULOSIS OF ADRENALS AND GASTROINTESTINAL TRACT		INTERVAL BETWEEN ONSET AND DEATH RECENT CHRONIC CHRONIC	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CARCINOMA OF LARYNX AND CARCINOMA OF TONSIL		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Feb. 10, 1967 to April 21 1967 that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 21 1967 , and that death occurred at 7:10 PM , from causes and on the date stated above.			
22a. SIGNATURE Alfonso A. Lopez		22b. DATE SIGNED 4/22/67	
22c. PHYSICIAN'S NAME (Type) ALFONSO A. LOPEZ, M.D.		22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-26-67	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Morton & Dyett Funeral Home		25a. RECEIVED BY REGISTRAR APR 25 1967	
ADDRESS 1701-31 Laurens St. Baltimore, Maryland		25b. REGISTRAR'S SIGNATURE Francis Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04895

04895

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 30 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL		e. STREET ADDRESS 3716 BARRINGTON ROAD	
3. NAME OF DECEASED (Type or print) First ULYSSES Middle SIMPSON Last SIMS		4. DATE OF DEATH Month APRIL Day 7 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 3, 1896
9. AGE (In years last birthday) yrs. 70		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WAITER		11b. KIND OF BUSINESS OR INDUSTRY Club	
12. BIRTHPLACE (County & State, or foreign country) TAMPA, FLORIDA		13. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. FATHER'S NAME PETER SIMS		15. MOTHER'S MAIDEN NAME MARIA KING	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		17. SOCIAL SECURITY NO. 115 03 31 97	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PNEUMONIA 493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CEREBROVASCULAR ACCIDENT,		INTERVAL BETWEEN ONSET AND DEATH 3-4 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
21. TIME OF INJURY Month, Day, Year Hour "a.m." p.m. 19		22. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
23. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		24. (City or town) (County) (State)	
25. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 8 , 19 67 , to APRIL 7 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 7 , 19 67 , and that death occurred at 4:05P M, from causes and on the date stated above.			
26. SIGNATURE <i>Carmelita A. Cendana</i>		27. DATE SIGNED 4-9-67	
28. PHYSICIAN'S NAME (Type) CARMELITA A. CENDANA		29. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND	
30. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		31. DATE THEREOF 4/12/67	
32. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		33. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
34. FUNERAL DIRECTOR HERBERT E. NUTTER		35. ADDRESS FUNERAL HOME, 3035 W. NORTH AVE, BALTIMORE, MD.	
36. REC'D BY REGISTRAR APR 11 1967		37. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04896

CERTIFICATE OF DEATH

04896

1. PLACE OF DEATH o. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Carroll			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Howard				c. LENGTH OF STAY IN 1b 30 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Airy	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ROY ELMONT SKEGGS				4. DATE OF DEATH Month Day Year APRIL 8 1967			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/31/91	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police Chief		10b. KIND OF BUSINESS OR INDUSTRY Police	
11. BIRTHPLACE (County & State, or foreign country) Kempton, Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Henry Skeggs				14. MOTHER'S MAIDEN NAME Virginia Jay			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes WW I				16. SOCIAL SECURITY NO. 218-10-84-84		17. INFORMANT Clin. Rec. VAH, Fort Howard, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 465X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRONCHITIS AND PULMONARY EMPHYSEMA						INTERVAL BETWEEN ONSET AND DEATH RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 9, 1967 , to April 8, 1967 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 8, 1967 , and that death occurred at 7:20 A.M. , from causes and on the date stated above.							
22a. SIGNATURE Isabelita Y. Cordoba, M.D.				22b. DATE SIGNED 4/8/67		22c. PHYSICIAN'S NAME (Type) ISABELITA Y. CORDOBA, M.D.	
22d. ADDRESS VA HOSPITAL, FORT HOWARD, MARYLAND							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 11, 1967		23c. NAME OF CEMETERY OR CREMATORY Pinegrove Cemetery		23d. LOCATION (City or Town) (County) (State) Mt. Airy Carroll Md.	
24. FUNERAL DIRECTOR Olin L. Molesworth Olin Molesworth Funeral Home				25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04897

CERTIFICATE OF DEATH

04897

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		c. LENGTH OF STAY IN 1b <u>4714 FREDERICK AVE</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PARADISE NURSING HOME</u>		d. STREET ADDRESS <u>BALTIMORE - MD</u>	
3. NAME OF DECEASED (Type or print) First <u>JONAS</u> Middle <u>(John)</u> Last <u>SLIBURIS</u>		4. DATE OF DEATH Month <u>4</u> - Day <u>4</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-2-1883</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TAILOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CLOTHING</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>LITH.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>SLIBURIS</u>		14. MOTHER'S MAIDEN NAME <u> </u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-03-8681A</u>	
17. INFORMANT <u>MRS. ELIZABETH SLIBURIS</u>		Address <u>4714 Frederick</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>C. V. D.</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized arteriosclerosis.</u> DUE TO (c) <u> </u>			INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o) <u> </u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u> </u> , 1962, to <u>4.4</u> , 1967, that (I) (we) last saw the deceased alive on <u>4.4</u> 1967, and that death occurred at <u>7:50 P.M.</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Stanley Ankudas</u>		22b. DATE SIGNED <u>4.5.67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stanley Ankudas, M.D.</u>		22d. ADDRESS <u>1101 Maiden Choice Lane #21229</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4/7/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>MONTICLOE CEMETERY</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE MD</u>
24. FUNERAL DIRECTOR <u>Thomas J. Koway Inc 1600 Heller St</u>		25a. REC'D BY REGISTRAR DATE <u>APR 6 1967</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04834

CERTIFICATE OF DEATH

04834

NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		ETHNIC ORIGIN	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	
NAME OF DECEASED		DATE OF BIRTH		PLACE OF BIRTH	
SEX		AGE		OCCUPATION	
MARRIED		SINGLE		EDUCATION	
RELIGION		RACE		ETHNIC ORIGIN	
CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESS		SIGNATURE OF MINISTER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
PLACE OF SIGNATURE		PLACE OF SIGNATURE		PLACE OF SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04898

CERTIFICATE OF DEATH

04898

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>BALTO.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>321 STRATFORD Rd</u>				d. STREET ADDRESS <u>321 STRATFORD Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROSALIE</u> Middle <u>SLINGERLAND</u> Last <u>SLINGERLAND</u>				4. DATE OF DEATH Month <u>APRIL</u> Day <u>11</u> Year <u>1967</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 25 1869</u>		9. AGE (In years last birthday) yrs. <u>97</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>LAUREL Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ANDREW FLEASTER</u>				14. MOTHER'S MAIDEN NAME <u>MARY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Ashby Eubank</u> Address <u>321 STRATFORD Rd #28</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardio-vascular Disease</u> <u>43801</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH <u>years</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>Sept.</u> , 19 <u>56</u> , to <u>April</u> , 19 <u>67</u> that (I) <u>we</u> last saw the deceased alive on <u>March 29 1967</u> , and that death occurred at <u>10:45A</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Leo J. Gaver</u>				22b. DATE SIGNED <u>4/12/67</u>		22c. PHYSICIAN'S NAME (Type) <u>Leo J. Gaver, M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>4/14/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill</u>		23d. LOCATION (City or Town) (County) (State) <u>LAUREL Md.</u>	
24. FUNERAL DIRECTOR <u>E.S. Mac Nab</u> ADDRESS <u>301 Frederick Rd Balto 28 Md</u>				25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

88810

82240

APR 1 1981

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

04899

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04899

1. PLACE OF DEATH a. COUNTY BALTIMORE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD				c. LENGTH OF STAY IN 1b 17 DAYS			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last WALTER CLAY SMALLWOOD				4. DATE OF DEATH Month Day Year APRIL 29, 1967			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/23/93	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRIVER-SALESMAN			10b. KIND OF BUSINESS OR INDUSTRY LAUNDRY		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME WILLIAM SMALLWOOD				14. MOTHER'S MAIDEN NAME FLORENCE IGLEHEART			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WWI		18. SOCIAL SECURITY NO. 216 03 62 49		17. INFORMANT Address CLINICAL RECORDS, VAH, FT. HOWARD, MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 9037 FRACTURE LEFT HIP DUE TO (b) TERMINAL BRONCHIAL PNEUMONIA DUE TO (c) CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), SETTING THE UNDERLYING CAUSE LAST.							INTERVAL BETWEEN ONSET AND DEATH 17 DAYS 24 HOURS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) FELL ON FLOOR AND BROKE HIP					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. APRIL 12 1967		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) VAH, FT. HOWARD		20f. (City or town) (County) (State) FORT HOWARD, BALTO., MD.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>M. B. Davis</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22. DATE SIGNED 4/29/67	
EXAMINER'S NAME (Type) MELVIN B. DAVIS, MD		Address (Street, city, town, or county) DUNDALK, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/67		23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEMETERY		23d. LOCATION (City, town or county) (State) 4300 OLD FRED. RD., BALTO., MD.	
24. FUNERAL DIRECTOR WALTERS FUNERAL HOME		ADDRESS PRATT AND STRICKER STS. BALTIMORE, MARYLAND		25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

<div style="display: flex; justify-content: space-between;"> <div> <div>5</div> <div>1</div> </div> <div> <div>04900</div> <div>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>CERTIFICATE OF DEATH</div> <div>04900</div> </div> </div>												
1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Balto</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - BALTIMORE</u>						
c. LENGTH OF STAY IN 1b <u>15 yrs</u>						d. STREET ADDRESS <u>3401 FAIRVIEW Avenue</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>3401 FAIRVIEW Avenue</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First <u>FREDERICK</u> Middle <u>WILLIS</u> Last <u>SMITH</u>						4. DATE OF DEATH Month <u>4</u> Day <u>13</u> Year <u>1967</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/3/1883</u>		9. AGE (In years last birthday) <u>83</u> yrs.		10. FUND 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRINTER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTING</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u> </u>						14. MOTHER'S MAIDEN NAME <u> </u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or, unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-09-8709</u>		17. INFORMANT <u>MA ROBERT SMITH</u>				Address <u>322 E. Tinnerly Rd.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO (b) <u>HYPERTENSION</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>OCTO 1952</u> to <u>4/13, 1967</u> , that (I) <u>twice</u> last saw the deceased alive on <u>4/12, 1967</u> , and that death occurred at <u>2007</u> M, from the causes and on the date stated above.												
22a. SIGNATURE <u>Edwin L. Pierpont</u>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>4/13/67</u>				
22c. PHYSICIAN'S NAME (Type) <u>EDWIN L. PIERPONT, M.D.</u>						22d. ADDRESS <u>8204 LIBERTY RD - BALTO, 21209 MD.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>4/15/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>			23d. LOCATION (City, town or county) (State) <u>3801 Frederick Ave. Balt. 21229</u>				
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>						25a. REC'D BY REGISTRAR <u>APR 17 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

MEDICAL CERTIFICATION

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04901

Items #8 & 9 Film #G388 5/1/67 ps

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04902

1. PLACE OF DEATH a. COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Balto.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Randallstown	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Baltimore County General Hosp.		d. STREET ADDRESS 8521 Glenn Michael Lane	
3. NAME OF DECEASED (Type or print) First Joseph Middle A. Last Sollod		4. DATE OF DEATH Month Apr. Day 5 Year 67	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/10/07 AGE (In years last birthday) 80 19 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Retired	11. BIRTHPLACE (State or foreign country) Russia
13. FATHER'S NAME Hyman Sollod		14. MOTHER'S MAIDEN NAME Chia ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-10-2182	17. INFORMANT Mrs. Anna Sollod, 8521 Glenn Michael Lane,
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Rheumatic Hypertensive Arteriosclerotic C-V Dis. 416 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 10 yrs.
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour none Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE D. D. Caples		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) D. D. Caples, M. D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF April 6, 1967	
23c. NAME OF CEMETERY OR CREMATORY ROSEDALE		23d. LOCATION (City or Town) (County) (State) BALTO MD	
24. FUNERAL DIRECTOR Sylvan S. Lewis & Son, P.O. Box 65, Garrison, Md.		25a. REC'D BY REGISTRAR APR 7 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge		22. DATE SIGNED 4-5-67	

30011

WIZARD

30011

30011

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04902

CERTIFICATE OF DEATH

04903

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>		c. LENGTH OF STAY IN 1b <u>4 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Baltimore County General</u>		d. STREET ADDRESS <u>Rt. 2 Box 353</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>F.</u> Last <u>Spurrer</u>		4. DATE OF DEATH Month <u>4</u> Day <u>3</u> Year <u>1967</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/26/97</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Spurrer Anthony</u>		14. MOTHER'S MAIDEN NAME <u>Krammer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>215-34-8600</u>	
17. INFORMANT <u>Hospital chart</u>		Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Pulmonary Emphysema</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>terminal 2° Chronic Lung Disease</u> DUE TO (c) <u>Generalized Arteriosclerotic Cardiovascular Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> o.m. <u> </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>3-31</u> , 19 <u>67</u> , to <u>4-3</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>6:50a</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Simon</u>		22b. DATE SIGNED <u>4-3-67</u>	
22c. PHYSICIAN'S NAME (Type) <u> </u>		22d. ADDRESS <u> </u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>4-6-67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>LOZDON PARK CEMET.</u>	23d. LOCATION (City or Town) (County) (State) <u>BALTIMORE, MD.</u>
24. FUNERAL DIRECTOR <u>WALTERS FUNERAL HOME</u>		25a. REC'D BY REGISTRAR <u>PRATT STRICKER</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>APR 6 1967</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

04809

04305

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04903

CERTIFICATE OF DEATH

04904

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore, 21212			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1571 Stonewood Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William E. Steadman				4. DATE OF DEATH Month Day Year April 17 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26 1910	9. AGE (In years last birthday) 57 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Marvelite Paint Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward V. Steadman				14. MOTHER'S MAIDEN NAME Mary. E. Cain			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 215-10-6325		17. INFORMANT Mrs. Mary R. Steadman		Address (Same)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized carcinomatosis. 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Carcinoma of head of pancreas. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Multiple small pulmonary emboli.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 17, 19 67 , to April 17 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 17 19 67 , and that death occurred at 7.10 PM on causes and on the date stated above.							
22a. SIGNATURE M.S. Cockburn, M.D.				22b. DATE SIGNED April 18, 1967		22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/21/67.		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE APR 19 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

2020

50299

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04904

CERTIFICATE OF DEATH

04905

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) House in the Pines Nursing Home		d. STREET ADDRESS 158 Stonecroft Apts.	
3. NAME OF DECEASED (Type or print) William Perry Stedman		4. DATE OF DEATH Month April Day 3 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 1, 1881
9. AGE (In years last birthday) 85 8/12 yrs.		10. IF UNDER 1 YEAR Months 4 Days 4 Hours 15 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Insurance business		10b. KIND OF BUSINESS OR INDUSTRY National Life Ins. Co.	
11. BIRTHPLACE (County & State, or foreign country) Waterbury, Conn		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Henry Taylor Stedman		14. MOTHER'S MAIDEN NAME Dobey	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Henry T. Stedman		Address Severna Park Maryland 30 Boone Trail	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac failure DUE TO (b) arteriosclerotic cardiovascular disease DUE TO (c) 4221 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH 6 wks 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (the hospital) attended the deceased from 1950 , 19 April 3 , 1967, that (I) (we) last saw the deceased alive on April 2 , 1967, and that death occurred at 5:20 P. M, from causes and on the date stated above.			
22a. SIGNATURE John A. Nesbitt Jr.		22b. DATE SIGNED 4-4-67	
22c. PHYSICIAN'S NAME (Type) John A. Nesbitt Jr. M.D.		22d. ADDRESS 1009 Frederick Rd. Catonsville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation	23b. DATE THEREOF Apr. 4, 1967	23c. NAME OF CEMETERY OR CREMATORY Loudon Park Crematory	23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR APR 6 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04905

04906

1. PLACE OF DEATH o. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>---</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			c. LENGTH OF STAY IN 1b <u>9 day</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore city</u> <u>304</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Greater Baltimore Med Center</u>				d. STREET ADDRESS <u>6010 Glen Oak Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Gerhard</u> First <u>L</u> Middle <u>Steep</u> Last				4. DATE OF DEATH Month <u>4</u> Day <u>23</u> Year <u>1967</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>CAU.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10-29-94</u>	
9. AGE (In years lost birthday) <u>72</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Arm's Watch Service</u>		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years lost birthday) <u>72</u> yrs.	
11. BIRTHPLACE (County & State, or foreign country) <u>Baltimore Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sigmund M. Steen</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>---</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>217-05-7923</u>		17. INFORMANT <u>Phys chart</u> Address <u>---</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>hemophysis massive</u> <u>7831</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-14</u> , 19 <u>67</u> , to <u>4-23</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-23</u> , 19 <u>67</u> , and that death occurred at <u>9:46</u> p.m., from causes and on the date stated above.							
22a. SIGNATURE <u>H. Margaret Zassenhaus, M.D.</u>				22b. DATE SIGNED <u>4-23-67</u>		22c. PHYSICIAN'S NAME (Type) <u>H MARGRET ZASSENHAUS</u>	
22d. ADDRESS <u>7028 BELLONA AVE BALTIMORE 12, MD</u>							
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>4/27/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		23d. LOCATION (City or town) (County) (State) <u>Balto -</u>	
24. FUNERAL DIRECTOR <u>W. Steemann 6067 Harford Rd</u>				25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

2020

suicidare regulament

Steen

44-42-01

Baltimore Md

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be directed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04906

CERTIFICATE OF DEATH

04901

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN It d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 314 Riverside Drive				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex d. STREET ADDRESS 314 Riverside Drive				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Irene E. Stephens				4. DATE OF DEATH Month April Day 29 Year 19 67					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct, 1888		9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS.: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never worked				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George Morris				14. MOTHER'S MAIDEN NAME Jeanette					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT Mr. Boyde H. Stephens Address same address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory failure DUE TO (b) coronary occlusion Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. Generalized arteriosclerosis - Hypertensive CVD PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia, severe.								INTERVAL BETWEEN ONSET AND DEATH few minutes few minutes several hours	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from January 7, 1967 to April 29, 1967 that (I) saw the deceased alive on April 26, 1967, and that death occurred at 11:30 AM, from the causes and on the date stated above.									
22a. SIGNATURE Eugene C. Baumann				22b. DATE SIGNED 5-2-67		22c. PHYSICIAN'S NAME (Type) EUGENE C. BAUMANN			
23a. BURIAL, CREMATION, REMOVAL Burial				23b. DATE THEREOF 5/3/1967		23c. NAME OF CEMETERY OR CREMATORY Mt. Carmel Cemetery		23d. LOCATION (City, town or county) Baltimore, Md.	
24 FUNERAL DIRECTOR'S SIGNATURE Wm. T. Tucker & Son				25a. REC'D BY REGISTRAR Balt. Md.		25b. REGISTRAR'S SIGNATURE Charles J. Jones		25c. DATE MAY 3 1967	

04301

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AND STATE DEPARTMENT

MAY 2 1964

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04907

CERTIFICATE OF DEATH

04907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Joseph Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u> 131 d. STREET ADDRESS <u>421 Warren Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Bruce T Strailman</u>			4. DATE OF DEATH Month Day Year <u>4-26-1967</u> 19				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Wh</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-29-1898</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Maryland</u>			
13. FATHER'S NAME <u>Charles Strailman</u>			14. MOTHER'S MAIDEN NAME <u>Lidia E Baer</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>213 34 9279</u>		17. INFORMANT Address <u>Wm. Bruchey 786 Charing Cross Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute congestive heart failure</u> <u>4221</u> DUE TO <u>arteriosclerotic cardio vascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>12-1</u> , 19 <u>54</u> , to <u>4-26</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4-20</u> 19 <u>67</u> , and that death occurred at <u>4</u> PM, from causes and on the date stated above.					
22a. SIGNATURE <u>John Gould</u>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D.		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>JOHN J GOULD</u>			22d. ADDRESS <u>14 N. EAST AVE-21224</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4-29-1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem</u>			
23d. LOCATION (City or Town) (County) (State) <u>Balto Md</u>		24. FUNERAL DIRECTOR ADDRESS <u>Thomas J Kerry, Inc 1600 Hollins st</u>					
25a. REC'D BY REGISTRAR DATE <u>APR 28 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

04307

CERTIFICATE OF DEATH

04307

STATE OF NEW YORK

DEPARTMENT OF HEALTH

OFFICE OF THE STATE COMMISSIONER OF HEALTH

ALBANY, NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04908

CERTIFICATE OF DEATH

04908

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland Va. b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Owings Mills		c. LENGTH OF STAY IN 1b 83.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rosewood State Hospital		d. STREET ADDRESS St. Gabriel's Home Av. 1302 Carrollton <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES	
3. NAME OF DECEASED (Type or print) First Gretchen Middle Gabrielle Last STREETT		4. DATE OF DEATH Month April Day 15 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-11-51
9. AGE (In years last birthday) 16 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent		10b. KIND OF BUSINESS OR INDUSTRY none	
11. BIRTHPLACE (County & State, or foreign country) Anne Arundel Co., Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Corbin Streett		14. MOTHER'S MAIDEN NAME Hildegard Volkmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Rosewood Records, Owings Mills, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stelecrosis bilateral marked 3255 DUE TO Cerebral hypodosis (Batten's disease) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 13 yrs (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) institutionalization due to spastic quadriplegia			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 13 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that 1 (this hospital) attended the deceased from April 19, 1963 , to April 15, 1967 , that 1 (we) last saw the deceased alive on April 15, 1967 , and that death occurred at 10:25 PM , from causes and on the date stated above.			
22a. SIGNATURE Richard A. Jones		22b. DATE SIGNED 15 April 1967	
22c. PHYSICIAN'S NAME (Type) Richard A. Jones		22d. ADDRESS Rosewood State Hosp.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/67	
23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION (City or Town) (County) (State) Balto., Md.	
24. FUNERAL DIRECTOR Mitchell-Wiedefeld Home		25a. REC'D BY REGISTRAR APR 18 1967	
ADDRESS 6500 York Rd.		25b. REGISTRAR'S SIGNATURE Charles Judge	
Balto., Md. 21212			

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items #8 & 9 Film #G387 1/18/67 pc

04903

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04909

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dundalk			c. LENGTH OF STAY IN 1b 31 Yrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1929 Crafton Ave.			d. STREET ADDRESS 1929 Crafton Ave.		
3. NAME OF DECEASED (Type or print) First John Middle W. F. Last Sudbrink Sr.			4. DATE OF DEATH Month April Day 8 Year 19 67		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/16/82 1885	9. AGE (In years last birthday) yrs. 81 1/2	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John W. H. Sudbrink			14. MOTHER'S MAIDEN NAME Not Known		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 213-09-0457		17. INFORMANT (Wife) Mrs. Jennie Sudbrink Address Dundalk, Md. 1929 Crafton Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) H-S-C-V-DISEASE 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None					INTERVAL BETWEEN ONSET AND DEATH —
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	
20f. (City or town) (County) (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Melvin B Davis M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 4/11/67	
EXAMINER'S NAME (Type) Melvin B Davis		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Dundalk, Md.		Address (Street, city, town, or county) 6800 Morningson Rd.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/12/67	23c. NAME OF CEMETERY OR CREMATORY Bel Air Mem. Gardens Cem.		23d. LOCATION (City or Town) (County) (State) Bel Air Maryland	
24. FUNERAL DIRECTOR John J. Duda ADDRESS 7922 Wise Ave. Dundalk, Md.			25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

04910

04910

1. PLACE OF DEATH a. COUNTY BALTIMORE b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE c. LENGTH OF STAY IN 1b 11 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY BALTIMORE c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) BALTIMORE d. STREET ADDRESS 4406 WENTWORTH ROAD e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARIAN VIRGINIA SUTER			4. DATE OF DEATH Month 4 Day 22 Year 1967				
5. SEX FEM.	6. COLOR OR RACE CAU.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/15/43	9. AGE (In years last birthday) 24 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) BALTO., MD			
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME JOHN FREDERICK LUTZ				
14. MOTHER'S MAIDEN NAME CASHELL			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO				
16. SOCIAL SECURITY NO. 215-42-6700			17. INFORMANT PHS Henry B. Suter-4406 Wentworth Ave.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant tumor (Probably lymphoma) with wide spread metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DOE TO (c) DOE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH		
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 4-12 , 19 67 , to 4-22 , 19 67 , that (I) (we) last saw the deceased alive on 4-22- 19 67 , and that death occurred at 5:45 AM, from the causes and on the date stated above.							
22a. SIGNATURE Kuwilsky					22b. DATE SIGNED 4-22-67		
22c. PHYSICIAN'S NAME (Type) Dora C Kuwilsky MD			22d. ADDRESS Greater Baltimore Medical Center				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4-24-1967	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery	23d. LOCATION (City, town or county) (State) Baltimore, Maryland				
24. FUNERAL DIRECTOR ELLSWORTH ARMAGOST		ADDRESS 4600 Lib. Hghts. Ave		25a. REC'D BY REGISTRAR APR 24 1967	25b. REGISTRAR'S SIGNATURE Charles Judge		

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GREATER BALTIMORE MEDICAL CENTER 400 WESTWORTH ROAD

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HOUSEWIFE BALTIMORE MD 0124

JOHN FREDERICK LUTZ CASHIER

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4-35-01 4-12 4-55-01

Dr. C. Kowalski MD Greater Baltimore Medical Center

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04911

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04911

1. PLACE OF DEATH a. COUNTY Baltimore, MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b Hours	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234		d. STREET ADDRESS 7603 Perring Terrace	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Susan Middle Victoria Last Switzer		4. DATE OF DEATH Month April Day 14 Year 1967	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 6, 1943
9. AGE (In years last birthday) 24 yrs.		IF UNDER 1 YEAR Months 14 Days 14 Hours 14 Min.	IF UNDER 24 HRS. Hours 14 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Secretary		10b. KIND OF BUSINESS OR INDUSTRY Baltimore, Maryland	
11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Aubrey J. Switzer		14. MOTHER'S MAIDEN NAME Audrey M. Carson	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 217-40-1360	
17. INFORMANT Mr. & Mrs. Aubrey J. Switzer		Address 7603 Perring Terr.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of abdomen 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) shot self in abdomen DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) shot self in abdomen 20c. TIME OF INJURY Month, Day, Year 4/15/67; 4:15 PM 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) home 20f. (City or town) (County) (State) Balto. 21234, Baltimore, Md.			INTERVAL BETWEEN ONSET AND DEATH
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
ACTUAL SIGNATURE Werner V. Spitz EXAMINER'S NAME (Type) Werner V. Spitz, M. D.		22. DATE SIGNED April, 15, 1967	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/18/67	
23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland 21234	
24. FUNERAL DIRECTOR Wm. Cook-Brooks Towson 1050 York Rd. 21204		25. REC'D BY REGISTRAR APR 20 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

11880

11880

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04912

CERTIFICATE OF DEATH

04912

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Howard			c. LENGTH OF STAY IN 1b 2 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Monkton			13.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Veterans Administration Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HARRY Middle AMBROSE Last TALBOTT				4. DATE OF DEATH Month April Day 2 Year 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/26/91		9. AGE (In years last birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James E. Talbott				14. MOTHER'S MAIDEN NAME Ida L. Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 215 32 39 21		17. INFORMANT Address Clinical Rcds, VA Hospital, Ft Howard, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY CONGESTION AND EDEMA 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) BRONCHOPNEUMONIA DUE TO (c) INTERVAL BETWEEN DEATH RECENT RECENT							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ARTERIOSCLEROTIC HEART DISEASE							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 3/31 , 19 67 , to April 2 , 19 67 , that (x) (we) last saw the deceased alive on 4/2 , 19 67 , and that death occurred at 9:05 M, from causes and on the date stated above.							
22a. SIGNATURE <i>[Signature]</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> M.D.		22b. DATE SIGNED 4/3/67	
22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.				22d. ADDRESS VA Hospital, Fort Howard, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/5/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND		
24. FUNERAL DIRECTOR <i>[Signature]</i>		ADDRESS JOSEPH N. ZANNINO FUNERAL		25a. REC'D BY REGISTRAR APR 10 1967		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
257 S. CONKLING ST. BALTIMORE, MD.							

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STATE OF TEXAS

IN SENATE,
January 1, 1901.
REPORT
OF THE
COMMISSIONER OF THE
LAND OFFICE,
FOR THE YEAR
1900.

ALBUQUERQUE, N. M.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04913

CERTIFICATE OF DEATH

04913

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		c. LENGTH OF STAY IN 1b <u>37 yr. 2 mo 17 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		30.4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING GROVE STATE Hospital</u>		d. STREET ADDRESS <u>1204 St. Paul Street</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mae</u> Middle <u>Templeman</u> Last <u>Taylor</u>		4. DATE OF DEATH Month <u>April</u> Day <u>12</u> Year <u>1967</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1904</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months _____ Days _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Robertson Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Mae Templeman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: SPRING GROVE STATE Hospital</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <u>Cirrhosis of the Liver</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) (this hospital) attended the deceased from <u>MARCH 12, 1967</u> , to <u>APRIL 12, 1967</u> , that (I) (we) last saw the deceased alive on <u>APRIL 12, 1967</u> , and that death occurred at <u>10:00 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Evelio H. Felipe M.D.</u>		22b. DATE SIGNED <u>4-12-67</u>	
22c. PHYSICIAN'S NAME (Type) <u>Evelio H. Felipe M.D.</u>		22d. ADDRESS <u>SPRING GROVE STATE Hospital Baltimore, Maryland 21228</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>		23b. DATE THEREOF <u>4/13/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Chenwood Cem</u>		23d. LOCATION (City or Town) _____ (County) _____ (State) _____	
24. FUNERAL DIRECTOR <u>Ulrich Funeral Home</u>		25a. REC'D BY REGISTRAR <u>APR 14 1967</u>	
ADDRESS <u>4210 Belair Rd.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

01013

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04914

CERTIFICATE OF DEATH

04914

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lutherville			c. LENGTH OF STAY in 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 105 Charmuth Road-21204				d. STREET ADDRESS 105 Charmuth Rd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) RANDOLPH Dean TAYLOR First Middle Last				4. DATE OF DEATH April 12th, 1967 Month Day Year			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/20/1902	9. AGE (In years last birthday) 64 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman Balto.		10b. KIND OF BUSINESS OR INDUSTRY Dental Lab.		11. BIRTHPLACE (County & State, or foreign country) Phila. Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles E. Taylor				14. MOTHER'S MAIDEN NAME Velna Dean			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-01-6831		17. INFORMANT Address Mrs. Betty J. Taylor 105 Charmuth Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction ± 30 minutes 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, cerebral ± 5 yrs. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) No		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury.					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from April 21, 1953 , to April 12, 1967 , that (I) (we) last saw the deceased alive on 5 April 1967 , and that death occurred at 9 A.M. from causes and on the date stated above.							
22a. SIGNATURE Edward L. J. Molz				22b. DATE SIGNED 14 April 67		22c. PHYSICIAN'S NAME (Type) Edward L. J. Molz M.D.	
22d. ADDRESS 7425 Harford Road							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/15/67	23c. NAME OF CEMETERY OR CREMATORY Western		23d. LOCATION (City or Town) (County) (State) Balto., Md.		
24. FUNERAL DIRECTOR ADDRESS Darby Funeral Home 300 Shipley St.				25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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04915

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY 304			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 1717 MORELAND AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First RAYMOND Middle BERNARD Last TAYLOR				4. DATE OF DEATH Month APRIL Day 1 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 26 1907		9. AGE (In years last birthday) 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ACCOUNTANT		10b. KIND OF BUSINESS OR INDUSTRY U. S. GOVERNMENT		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON, D. C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HILLARY TAYLOR				14. MOTHER'S MAIDEN NAME SARAH AUGUSTA CLARK			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. 215 44 79 79		17. INFORMANT VA HOSPITAL CLINICAL RECORDS FORT HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X CEREBRAL HEMORRHAGE, LEFT Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ADENOCARCINOMA, PROSTATE DUE TO (b) ADENOCARCINOMA, PROSTATE DUE TO (c) ADENOCARCINOMA, PROSTATE						INTERVAL BETWEEN ONSET AND DEATH RECENT UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from APRIL 1 , 19 67 , to APRIL 1 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 1 , 19 67 , and that death occurred at 500P M, from causes and on the date stated above.							
22a. SIGNATURE Jorge A. Fabara				22b. DATE SIGNED 4/3/67		22c. PHYSICIAN'S NAME (Type) JORGE A. FABARA, M. D.	
22d. ADDRESS VAH FORT HOWARD, MARYLAND				22e. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/6/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR ARLINGTON S. PHILLIPS FUNERAL HOME				25a. REC'D BY REGISTRAR APR 6 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04916

CERTIFICATE OF DEATH

04916

1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21234 d. STREET ADDRESS 9305 Harford Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Edith Middle Phoebe Last THATCHER		4. DATE OF DEATH Month April Day 3 Year 1967	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH June 17, 1902
9. AGE (In years last birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) COOK		10b. KIND OF BUSINESS OR INDUSTRY SPRINK REST.	
11. BIRTHPLACE (County & State, or foreign country) PA. U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNK		14. MOTHER'S MAIDEN NAME UNK	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 209-14-5082	
17. INFORMANT Hospit Records		Address -	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral infarction and hemorrhage of left hemisphere. DUE TO hemisphere. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Occlusion of left carotid artery. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that 10 (this hospital) attended the deceased from March 2, 1967 , to April 3, 1967 , that 1 (we) last saw the deceased alive on April 3, 1967 , and that death occurred at 11 A.M. from causes and on the date stated above.			
22a. SIGNATURE M.S. Cockburn M.D.		22b. DATE SIGNED April 5, 1967	
22c. PHYSICIAN'S NAME (Type) M.S. Cockburn, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF April 5, 1967	23c. NAME OF CEMETERY OR CREMATORY Mt Carmel Cem	23d. LOCATION (City or Town) (County) (State) O'Donnell St Baltimore Md
24. FUNERAL DIRECTOR Joseph N Zanning 263 S. Conkling St.		25a. REC'D BY REGISTRAR APR 7 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

04918

CONTINUATION OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04917

04917

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown</u>				c. LENGTH OF STAY IN 1b <u>5 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>BALTO. COUNTY GENERAL HOSPITAL</u>				d. STREET ADDRESS <u>6610 Windsor Mill Rd.</u>			
3. NAME OF DECEASED (Type or print) <u>EMMA Estella Thomas</u>				4. DATE OF DEATH Month <u>April</u> Day <u>27</u> Year <u>1967</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-17-95</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u></u> Hours <u></u> Min <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Frederick J. George Meister</u>				14. MOTHER'S MAIDEN NAME <u>Annie Klages - Beverly Kondner</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-46-2777-T.</u>		17. INFORMANT <u>Beverly Kondner</u> Address <u>6610 Windsor Mill Rd.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction. CVA</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ASAD; diabetes mellitus</u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> , 19 <u>67</u> , to <u>4/27</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/27/67</u> 19 <u></u> , and that death occurred at <u>7</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Milton Schlenker</u>				22b. DATE SIGNED <u>4-27-67</u>			
22c. PHYSICIAN'S NAME (Type) <u>Milton Schlenker</u>				22d. ADDRESS <u>6400 Windsor Mill Rd.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>5/1/67</u>		23c. NAME OF CEMETERY OR CREMATORY <u>LOUDON PARK</u>		23d. LOCATION (City or Town) (County) (State) <u>BALTO MD</u>	
24. FUNERAL DIRECTOR <u>John T. Stansbury</u>				25a. REC'D BY REGISTRAR <u>MAY 1 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04918

CERTIFICATE OF DEATH

04918

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ---			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN lb 61 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE 30-4		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 556 BLOOM STREET		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle EDWARD Last THOMAS				4. DATE OF DEATH Month APRIL Day 24 Year 19 67			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MAY 27, 1918		9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EUGENE THOMAS				14. MOTHER'S MAIDEN NAME HENRIETTA CHASE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW2		16. SOCIAL SECURITY NO. 218 09 84 07		17. INFORMANT Address CLIN. REC., VAH, FT. HOWARD, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4/201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) CHRONIC BRAIN SYNDROME. CHRONIC ALCOHOLISM. POSSIBLE PNEUMONITIS						INTERVAL BETWEEN ONSET AND DEATH RECENT	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour --- o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (a) (this hospital) attended the deceased from 2/23/67 to 4/24/67 , that (b) (we) last saw the deceased alive on 4/24/67 19 --- , and that death occurred at 12:50A M, from causes and on the date stated above.							
22a. SIGNATURE <i>Raul F. DeCastro</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/26/67	
22c. PHYSICIAN'S NAME (Type) RAUL F. DeCASTRO, M. D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/28/67		23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL		23d. LOCATION (City or Town) (County) (State) BALTIMORE, MARYLAND	
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR PHILLIPS FUNERAL HOME		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04913 CERTIFICATE OF DEATH 04919

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ruxton		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ruxton	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 1904 Indian Head Road		d. STREET ADDRESS 1904 Indian Head Road	
3. NAME OF DECEASED (Type or print) Dr. OSCAR B. THOMAS		4. DATE OF DEATH Month APRIL Day 3 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11/6/1882
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pharmacist		10b. KIND OF BUSINESS OR INDUSTRY Drugs	
11. BIRTHPLACE (County & State, or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Dutrow Thomas		14. MOTHER'S MAIDEN NAME Harriet Trundle	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 212-07-1442	
17. INFORMANT S. James Campbell		Address (Same)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMPHYSEMA 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 2 YEARS
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from OCT , 19 53 , to APR 3 , 19 67 , that (I) (we) last saw the deceased alive on APR 3 , 19 67 , and that death occurred at 8a. M, from the causes and on the date stated above.			
22a. SIGNATURE John M. Scott		22b. DATE SIGNED APR. 3, 1967	
22c. PHYSICIAN'S NAME (Type) Dr. John M. Scott		22d. ADDRESS 600 W. Belvedere Ave.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/6/1967	23c. NAME OF CEMETERY OR CREMATORY Druid Ridge	23d. LOCATION (City, town or county) (State) Pikesville, Balto. Co., Md.
24. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		25a. REC'D BY REGISTRAR APR 4 1967	
ADDRESS 4905 York Rd. Balto. 12, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

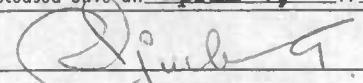
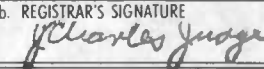
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04920

CERTIFICATE OF DEATH

04920

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3½ weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21222 Dundalk			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 7204 Kimmell Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Homer Middle L. Last Thompson		4. DATE OF DEATH Month April Day 4 Year 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 25, 1901	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Elmer Thompson				14. MOTHER'S MAIDEN NAME Emma Hazelton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes Army 1925		16. SOCIAL SECURITY NO. 216-10-3497		17. INFORMANT (Wife) Address Dundalk, Md. Mrs. Lucille Thompson 7204 Kimmell Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho-pneumonia 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Terminal carcinomatosis: primary in right lung.						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from March 10 , 19 67 , to April 4 , 1967, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 4 , 19 67 , and that death occurred at 2:50 PM , from causes on and on the date stated above.							
22a. SIGNATURE 		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 5, 1967			
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/7/67		23c. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.				25a. REC'D BY REGISTRAR DATE APR 10 1967		25b. REGISTRAR'S SIGNATURE 	

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04921

CERTIFICATE OF DEATH

04921

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b 21212			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21212	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 58 St. Josephs Hospital				d. STREET ADDRESS 1671 Northern Parkway			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Anton Middle Fred Last TOMASSETTI				4. DATE OF DEATH Month April Day 9 Year 19 67			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-27-15	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist		10b. KIND OF BUSINESS OR INDUSTRY Martin Marietta Co.		11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Doransino Tomassetti				14. MOTHER'S MAIDEN NAME Frances Ferretti			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) no		16. SOCIAL SECURITY NO. 12-07-7133		17. INFORMANT Address Wife - Annie Laura - same as patient			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Subarachnoid hemorrhage 443x DUE TO Subarachnoid hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive heart disease DUE TO Hypertensive heart disease (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (X) (this hospital) attended the deceased from April 2, 19 67 , to April 9, 19 67 , that (X) (we) last saw the deceased alive on April 9, 19 67 , and that death occurred at 6:15 PM, Mom causes and on the date stated above.							
22a. SIGNATURE Juana S. Cockburn M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4-10-67	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M.D.				22d. ADDRESS 7620 York Road, Baltimore, Md. 21204			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/13/67.		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214				25a. REC'D BY REGISTRAR DATE APR 11 1967		25b. REGISTRAR'S SIGNATURE Charles J. J...	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04922

Item #5 Film #G387 4/18/67 pc

CERTIFICATE OF DEATH

04922

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 21228		c. LENGTH OF STAY IN 1b 13 yrs.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Summit Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville 21228	
3. NAME OF DECEASED (Type or print) Cecil Edward Trinkaus		4. DATE OF DEATH Month April Day 6 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15, 1900
9. AGE (In years last birthday) 66 yrs.		10. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Postmaster U. S. Government Post Office		10b. KIND OF BUSINESS OR INDUSTRY Chicago, Ill.	
11. BIRTHPLACE (County & State, or foreign country) U. S. A.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME C. William Trinkaus		14. MOTHER'S MAIDEN NAME Ellen Teresa Forde	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 216-32-7961	
17. INFORMANT Mrs. Margaret K. Trinkaus		Address Catonsville, Md. 21228	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary failure 4344 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial damage DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Upper Respiratory Infection - Englewood		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/1/1 , 19 67 to 4/6 , 19 67 , that (I) (we) last saw the deceased alive on 4/5 , 19 67 , and that death occurred at 7:45 M, from causes and on the date stated above.			
22a. SIGNATURE Cecil R. Ratner		22b. DATE SIGNED 4/7/67	
22c. PHYSICIAN'S NAME (Type) CLIFF RATNER, JR.		22d. ADDRESS 4605 EDMONDSON AVE	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/10/1967	
23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Easton Funeral Home		25a. REC'D BY REGISTRAR APR 12 1967	
ADDRESS Catonsville, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
04923					04923					
Item #1d per telephone conv. with physician										
1. PLACE OF DEATH a. COUNTY Baltimore b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Essex c. LENGTH OF STAY IN 1b Essex d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 808 Creek Rd.					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 613 S. Milton Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) James Martin Tully					4. DATE OF DEATH 4 - 21 1967					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11 - 7 - 07		9. AGE (in years last birthday) 59 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Tully					14. MOTHER'S MAIDEN NAME Catherine Piechocka					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes			16. SOCIAL SECURITY NO. WW II 216 09 5015		17. INFORMANT Martha Tully 808 Creek Road #21					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of larynx DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 6 mo.		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 24 Mar. 1967 to 21 April 1967 , that (I) (we) last saw the deceased alive on 24 March 1967 , and that death occurred at 7:15 PM , from the causes and on the date stated above.										
22a. SIGNATURE M. Rainess M.D.					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4-21-67	
22c. PHYSICIAN'S NAME (Type) MORRIS RAINESS, M.D.					22d. ADDRESS 1105 OLD EASTERN AVE.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-25-67		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus			23d. LOCATION (City, town or county) (State) Baltimore Md.			
24. FUNERAL DIRECTOR Raymond L. Kaczorowski 2525 Fleet Street					25a. REC'D BY REGISTRAR MAY 1 1967		25b. REGISTRAR'S SIGNATURE Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>													
1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk c. LENGTH OF STAY IN 1b Minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 6800 Morningson Rd.						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Dundalk d. STREET ADDRESS 8524 Kavanagh Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leonard Middle D. Last Wagner				4. DATE OF DEATH Month April Day 16 Year 1967									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/2/16		9. AGE (in years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 03 Days 1		IF UNDER 24 HRS. Hours 00 Min. 00	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Foreman				10b. KIND OF BUSINESS OR INDUSTRY Both. Steel Co.		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Charles A. Wagner						14. MOTHER'S MAIDEN NAME Carrie B. Mossett							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 217-03-4959		17. INFORMANT (Wife) Mrs. Pearl Wagner, 8524 Kavanagh Rd.				Address Dundalk, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) A-S-C-V Disease DUE TO (c)										INTERVAL BETWEEN DEATH AND DEATH 2 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 4/16, 1967, to 4/16, 1967, that (I) (we) last saw the deceased alive on 4/14/67, 1967, and that death occurred at 1:30 P.M. from the causes and on the date stated above.													
22a. SIGNATURE M B Davis								22b. DATE SIGNED 4/17/67					
22c. PHYSICIAN'S NAME (Type) Melvin B. Davis				M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS 6800 Morningson Rd. Dundalk, Md, 21222					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/19/67		23c. NAME OF CEMETERY OR CREMATORY Baltimore Nat'l Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland							
24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.						25a. REC'D BY REGISTRAR APR 18 1967		25b. REGISTRAR'S SIGNATURE Charles Judge					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04925
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Shady Side Nursing Home</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Shady Side Nursing Home</u>		d. STREET ADDRESS <u>1231 Cleveland St.</u>	
3. NAME OF DECEASED (Type or print) <u>Christine M. Wallnofer</u>		4. DATE OF DEATH <u>April 16 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/25/1887</u>
9a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) <u>Housewife</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>at Home</u>	
10a. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		10b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. FATHER'S NAME <u>Theodore Sigwart</u>		12. MOTHER'S MAIDEN NAME <u>Katherine Wiseman</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>		14. SOCIAL SECURITY NO. <u>-</u>	
15. INFORMANT <u>Mrs. Alma Hodges Conbright</u>		Address <u>1340 Rd.</u>	
16. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fatal Hypostatic Pneumonia</u> 332X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Thrombotic Septic Thrombosis</u> DUE TO (c) <u>11/16/67</u> 174/66		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardio-Vascular Disease & Chronic Thrombosis 1/4/66</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>66</u> , to <u>4/16</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>4/15</u> , 19 <u>67</u> , and that death occurred at <u>7:22</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Johnson</u>		22b. DATE SIGNED <u>4/17/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD W. JOHNSON</u>		22d. ADDRESS <u>3432 Belvoir Ave</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>4/19/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>	23d. LOCATION (City, town or county) (State) <u>4430 Belair Rd.</u>
24. FUNERAL DIRECTOR <u>John J. Cowan & Son Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>901 Halling St.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
CITY <u>Baltimore</u>		DATE <u>APR 18 1967</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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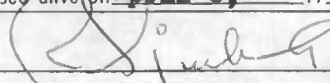
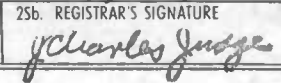
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04926

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21202			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital				d. STREET ADDRESS 1827 Aisquith St. #2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Joseph Last WAMHOFF		4. DATE OF DEATH Month April Day 8 Year 1967					
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 12, 1904	9. AGE (In years last birthday) yrs. 62	IF UNDER 1 YEAR Months 30 Days 4		IF UNDER 24 HRS. Hours 1 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Conveyer		10b. KIND OF BUSINESS OR INDUSTRY Schaeffer Brewing		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Frank Wamhoff			14. MOTHER'S MAIDEN NAME Margaret Snee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 218-03-9710		17. INFORMANT Address Frances Wamhoff, wife, above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal carcinomatosis, primary in colon. 1538 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that NO (this hospital) attended the deceased from January 21, 1967 , to April 8, 1967 , that NO (we) last saw the deceased alive on April 8, 1967 , and that death occurred at 10 A.M. from causes and on the date stated above.							
22a. SIGNATURE 		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 8, 1967			
22c. PHYSICIAN'S NAME (Type) Reynaldo Orjuela-Gomez, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/12/67	23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cemetery		23d. LOCATION (City or Town) (County) (State) Balto., Md.			
24. FUNERAL DIRECTOR Schimunek Funeral Home		25a. REC'D BY REGISTRAR APR 12 1967		25b. REGISTRAR'S SIGNATURE 			
24. ADDRESS 3331 Brehms Lane, #13							

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

04927

CERTIFICATE OF DEATH

04928

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Paradise Nursing Home				d. STREET ADDRESS 415 North Mt. Holly St. 29			
3. NAME OF DECEASED (Type or print)		First Meta Middle C. Last Warnken		4. DATE OF DEATH Month April Day 11 , Year 1967		a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 5, 1893	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months 7 Days 11	IF UNDER 24 HRS. Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Charlady		10b. KIND OF BUSINESS OR INDUSTRY Theater		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Ferdinand				14. MOTHER'S MAIDEN NAME Marie Sophia Berlincke			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Gordon L. Warnken		Address 9120 Hines Rd.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRAL HEMORRHAGE 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) ARTERIOSCLEROSIS (c) ARTERIOSCLEROSIS (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)						INTERVAL BETWEEN ONSET AND DEATH 13 DAYS 10 YEARS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2/8 , 1960 to 4/11 , 1967, that (I) (we) last saw the deceased alive on 4/11 , 1967, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Paul R. Ziegler				22b. DATE SIGNED 4/13/67			
22c. PHYSICIAN'S NAME (Type) PAUL R. ZIEGLER				22d. ADDRESS 200 CHESTNUT HILL DR. ELK CITY, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/14/1967		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City, town or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Wm. F. Tichner & Sons				25. REC'D BY REGISTRAR APR 13 1967			
25a. REGISTRAR'S SIGNATURE Charles Judge				25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04928

CERTIFICATE OF DEATH

04927

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH o. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE MARYLAND b. COUNTY BALTO. CITY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson			c. LENGTH OF STAY IN 1b ?	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE			30.4
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) GREATER BALTIMORE MEDICAL CENTER				d. STREET ADDRESS 358 CORNWALL STREET			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
NAME OF DECEASED (Type or print) First GLADYS Middle IRENE Last WARNER		4. DATE OF DEATH Month APRIL Day 4 Year 1967					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/22/1891	9. AGE (In years lost birthday) yrs. 75	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) CLEVELAND OHIO		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME WILLIAM DAVIDSON				14. MOTHER'S MAIDEN NAME BROWN, Louise			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 216-10-5149		17. INFORMANT ADMISSION SHEET		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio - Resp. Failure 1810 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of bladder DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (H) (this hospital) attended the deceased from 2/17/67 , to 4/4/67 , that (H) (we) last saw the deceased alive on 4/4/67 , and that death occurred at 7:40 P.M. , from causes and on the date stated above.							
22a. SIGNATURE Denis Chan				22b. DATE SIGNED 4/4/67		22c. PHYSICIAN'S NAME (Type) DENIS CHAN M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/9/1967		23c. NAME OF CEMETERY OR CREMATORY Druid Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Pikesville, Md.	
24. FUNERAL DIRECTOR Wm. J. Tribuna				25a. REC'D BY REGISTRAR DATE APR 5 1967		25b. REGISTRAR'S SIGNATURE [Signature]	

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STATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
04929					04929				
1. PLACE OF DEATH a. COUNTY <i>Baltimore</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Baltimore</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>			c. LENGTH OF STAY IN Ib		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Reisterstown</i>			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>616 Main Street</i>					d. STREET ADDRESS <i>616 Main Street</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Mary</i> First <i>E.</i> Middle <i>Warren</i> Last					4. DATE OF DEATH Month <i>April</i> Day <i>26</i> Year <i>1967</i>				
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Feb. 14, 1900</i>		9. AGE (In years last birthday) <i>67</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <i>Rock Hall, Md.</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>Walter Fields</i>					14. MOTHER'S MAIDEN NAME <i>Dora Deal</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-07-20350</i>		17. INFORMANT <i>Mr. Walter J. Warren</i>			Address <i>Owings Mills, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Occlusion</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <i>Arteriosclerotic-Hypertensive C.V. Dis.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <i>15 mins.</i> <i>13 yrs.</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>Jan. 17, 1953</i> to <i>Apr. 26, 1967</i> , that (I) (we) last saw the deceased alive on <i>March 3, 1967</i> and that death occurred at <i>7 AM</i> from the causes and on the date stated above.									
22a. SIGNATURE <i>Martin E. Strobel</i> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <i>4-27-67</i>	
22c. PHYSICIAN'S NAME (Type) <i>Martin E. Strobel, M.D.</i>					22d. ADDRESS <i>48 Main St. Reisterstown, Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>April 29, 67</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Pikesville, Md.</i>			
24 FUNERAL DIRECTOR'S SIGNATURE <i>J. F. Eline & Sons Reisterstown, Md.</i>					ADDRESS		25a. REC'D BY REGISTRAR <i>MAY 1 1967</i>		
							25b. REGISTRAR'S SIGNATURE <i>Richard J. Judge</i>		

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04930

CERTIFICATE OF DEATH

04930

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Relay				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1732 Arlington Ave. 21227				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Charles William Watts				4. DATE OF DEATH April 28 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 24, 1899		9. AGE (In years lost birthday) 67 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY U.S. Post Office		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George R. Watts				14. MOTHER'S MAIDEN NAME Jeannette Hettling			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Cordelia Estella J. Watts 1732 Arlington Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the esophagus 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Metastasis sec to (a) DUE TO (c) Cachexia sec to (a) & (b)						INTERVAL BETWEEN ONSET AND DEATH 3 6 mos 6 mos	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from OCT 1966 to 28 APRIL 1967 that (I) (we) last saw the deceased alive on 4-29 1967 , and that death occurred at 4:00 P.M. from causes and on the date stated above.							
22a. SIGNATURE Manuel Rodriguez				22b. DATE SIGNED 4-30-67		22c. PHYSICIAN'S NAME (Type) Manuel Rodriguez	
22d. ADDRESS 435 Chalfonte Drive 21228							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 5/2/67		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard				25a. REC'D BY REGISTRAR MAY 2 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH, NEW YORK STATE

DATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 42 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
04932 CERTIFICATE OF DEATH 04932

1. PLACE OF DEATH a. COUNTY Baltimore County		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Mount Wilson		c. LENGTH OF STAY IN 1b 25 days.		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland.		b. COUNTY Baltimore		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 612 E. Lombard St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) VERNON BENJAMIN WEBSTER.		4. DATE OF DEATH 4/13/1967.		5. SEX M		6. COLOR OR RACE W.		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/18/1909		9. AGE (In years last birthday) 57 yrs.		IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) 2 laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Webster		14. MOTHER'S MAIDEN NAME Hilda Horseman.		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.			
17. INFIRMANT Records, Mt. Wilson State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① Cirrhosis of the liver, and ② Hepatoma. 5811 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. ③ Chronic alcoholism. DUE TO 0021 (c)		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) ① Pulm. TB, moderately advanced, inactive ③ Anemia, due to #2.		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from 3/20/1967 to 4/13/1967 , that (I) (we) last saw the deceased alive on 4/13/1967 , and that death occurred at 4:15 AM , from the causes and on the date stated above.		22a. SIGNATURE Wm. Newcomer		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Wm. Newcomer, M.D., Superintendent		22d. ADDRESS Mount Wilson, Maryland		22e. REC'D BY REGISTRAR APR 20 1967		22f. REGISTRAR'S SIGNATURE J. Charles Judge	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF 4/18/67		23c. NAME OF CEMETERY OR CREMATORY Johns Hopkins School of Med. 709 N. Wolfe St. Balto. Md.		23d. LOCATION (City, town or county) (State)		24. FUNERAL DIRECTOR Newell Funeral Home Pikesville		24b. ADDRESS 8-2nd		25a. REC'D BY REGISTRAR APR 20 1967		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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Baltimore County

Mount Wilson

Mount Wilson State Hospital

Records, Mt. Wilson State Hospital

Superintendent, Mount Wilson, Maryland

4/15/67 Mount Wilson State Hospital

APR 24 1967

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04933

CERTIFICATE OF DEATH

04933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) TOWSON			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DULANEY TOWSON NURSING HOME				d. STREET ADDRESS 3809 BYFIELD ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Anna Middle Wendell Last				4. DATE OF DEATH April 23 19 67 Month Day Year			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (County & State, or foreign country) POLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME TOBIAS SADOWSKY				14. MOTHER'S MAIDEN NAME UNKNOWN			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. UNKNOWN		17. INFORMANT Address MR. MARTIN WENDELL, 3809 BYFIELD ROAD #7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Circulatory collapse 1992 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Carcinoma							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1965 , 19 to 4/21/67 , that (I) (we) last saw the deceased alive on 4/18/67 and that death occurred at 11:00 PM , from causes and on the date stated above.							
22a. SIGNATURE Leonard H. Golombek				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/22/67	
22c. PHYSICIAN'S NAME (Type) LEONARD H. GOLOMBEK				22d. ADDRESS 7039 LIBERTY ROAD			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4/23/67		23c. NAME OF CEMETERY OR CREMATORY RIVERSIDE		23d. LOCATION (City or Town) (County) (State) LODI, NEW JERSEY	
24. FUNERAL DIRECTOR SOL LEVINSON & BROS. INC., 6010 REIST., RD.				25a. REC'D BY REGISTRAR DATE APR 25 1967		25b. REGISTRAR'S SIGNATURE Charles Judge	

04333

CERTIFICATE OF DEATH

04333

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

NAME OF DECEASED

RESIDENCE OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

NAME OF DECEASED

RESIDENCE OF DECEASED

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DATE OF DEATH

PLACE OF DEATH

SEX

AGE

DATE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

NAME OF DECEASED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04934

CERTIFICATE OF DEATH

04934

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY —		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 3 hours	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 1244 Walker Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Gertrude Middle E. Last Wheeler			4. DATE OF DEATH Month April Day 18 Year 19 67		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/7/88		9. AGE (In years last birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Pennsylvania	
13. FATHER'S NAME Leopold Rosenzweig			14. MOTHER'S MAIDEN NAME Gertrude Coppe		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 172-18-6071		17. INFORMANT (Daughter) Mrs. Gertrude Redmond, 1244 Walker Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction DUE TO 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (1) (this hospital) attended the deceased from 1-9, 1967 to 4-17, 1967 , that (1) (we) last saw the deceased alive on 4-18, 1967 , and that death occurred at 5:00 M, from causes and on the date stated above.					
22a. SIGNATURE W. M. Smith		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/18/67	
22c. PHYSICIAN'S NAME (Type) W. M. Smith		22d. ADDRESS 16305 ALAMETA BALTO. MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/22/67		23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus Cemetery	
23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland		24. FUNERAL DIRECTOR John J. Duda, 7922 Wise Ave. Dundalk, Md.		25a. REC'D BY REGISTRAR APR 25 1967	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04935

CERTIFICATE OF DEATH

04935

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville				c. LENGTH OF STAY IN 1b 2 Yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Shangri-La Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William Baker Whitsitt				4. DATE OF DEATH Month Day Year April 25 19 67			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 27, 1888		9. AGE (In years last birthday) 78 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive and Power Superintendent			10b. KIND OF BUSINESS OR INDUSTRY Kentucky		11. BIRTHPLACE (County & State, or foreign country) U.S.A.		
13. FATHER'S NAME William Whitsitt				14. MOTHER'S MAIDEN NAME Florie Wallace			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Address Florie W. Clifford-2436 Pickwick Rd. #7			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intractable Chronic Heart Failure DUE TO Progressive generalized arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arterial Insufficiency DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 week 10 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on April 24, 19 67 , and that death occurred at _____ M, from causes and on the date stated above.							
22a. SIGNATURE Emidio A. Bianco M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 4/26/67	
22c. PHYSICIAN'S NAME (Type) Emidio A. Bianco, M. D.				22d. ADDRESS 3350 Wilkens Avenue, 21229			
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment		23b. DATE THEREOF 4-27-67		23c. NAME OF CEMETERY OR CREMATORY Lorraine Mausoleum		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Ellsworth Armacost-4600 Liberty Hghts. Ave.				25a. REC'D BY REGISTRAR APR 26 1967		25b. REGISTRAR'S SIGNATURE Charles J. [Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
 Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
 Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04936

CERTIFICATE OF DEATH

04936

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Towson		c. LENGTH OF STAY IN 1b 304		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 21211	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital			d. STREET ADDRESS 510 W. 33rd. St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Theresa Middle B. Last WICHERT			4. DATE OF DEATH Month April Day 13 Year 1967		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 19, 1898	9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months 6 Days 8 Hours 4 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME ?			14. MOTHER'S MAIDEN NAME ?		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Julia Kowalski 113 S. Robison St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that NO (this hospital) attended the deceased from April 12, 1967 , to April 13, 1967 , that NO (we) last saw the deceased alive on April 13, 1967 , and that death occurred at 8 A.M. from causes and on the date stated above.					
22a. SIGNATURE Fiorello G. Malit M.D.			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED April 13, 1967
22c. PHYSICIAN'S NAME (Type) Fiorello G. Malit, M.D.			22d. ADDRESS 7620 York Rd., Towson, Md. 21204		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 4/15/67	23c. NAME OF CEMETERY OR CREMATORY Oaklawn		23d. LOCATION (City or Town) (County) (State) Baltimore, Md.	
24. FUNERAL DIRECTOR Paul E. Chenoweth 3rd 3617 Chestnut Ave			25a. REC'D BY REGISTRAR APR 17 1967		25b. REGISTRAR'S SIGNATURE Charles Judge

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STATE OF CALIFORNIA

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>04937</p> </div> </div>													
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <u>Balto.</u> MARYLAND</p> <p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Towson</u></p> <p>c. LENGTH OF STAY IN 1b <u>30.4</u></p> <p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Dulaney Towson Nursing Home</u></p>						<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <u>md</u> b. COUNTY <u>Balto.</u></p> <p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Balto. 21229</u></p> <p>d. STREET ADDRESS <u>908 Kevin Rd</u></p> <p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>							
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <u>Louise</u> Middle <u>Widener</u> Last <u>Widener</u></p>		<p>4. DATE OF DEATH</p> <p>Month <u>4</u> Day <u>17</u> Year <u>1967</u></p>		<p>5. SEX <u>F</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>3-17-1905</u></p>		<p>9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County & State, or foreign country) <u>W. Va.</u></p>				<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u></p>			
<p>13. FATHER'S NAME <u>Frank Taylor</u></p>						<p>14. MOTHER'S MAIDEN NAME <u>Catherine</u></p>							
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT <u>Mr. John C. Widener</u> Address <u>908 Kevin Rd. - 21229</u></p>							
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <u>Metastatic Oedocarcinoma of</u></p> <p>1992 DUE TO <u>undetermined Primary</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>												<p>INTERVAL BETWEEN ONSET AND DEATH <u>6 Months</u></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p> <p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>													
<p>20c. TIME OF INJURY Month, Day, Year</p> <p>Hour a.m. p.m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>					
<p>21. I certify that (I) (this hospital) attended the deceased from <u>NOVEMBER 19 67</u> to <u>April 12, 19 67</u> that (I) (we) last saw the deceased alive on <u>4/16</u> 19<u>67</u>, and that death occurred at <u>5:25</u> A.M. from the causes and on the date stated above.</p>													
<p>22a. SIGNATURE <u>Jose Martinez MD</u></p>						<p>22b. DATE SIGNED <u>4/17/67</u></p>		<p>ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>					
<p>22c. PHYSICIAN'S NAME (Type) <u>JOSE MARTINEZ MD</u></p>						<p>22d. ADDRESS <u>100 N Broadway 21231</u></p>							
<p>23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>				<p>23b. DATE THEREOF <u>4-19-67</u></p>		<p>23c. NAME OF CEMETERY OR CREMATORY <u>New Cath.</u></p>		<p>23d. LOCATION (City, town or county) (State) <u>Balto., Md.</u></p>					
<p>24. FUNERAL DIRECTOR <u>Witzke F. D. - 4101 Edmondson Ave.</u></p>						<p>25a. REC'D BY REGISTRAR <u>APR 18 1967</u></p>		<p>25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u></p>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04938

CERTIFICATE OF DEATH

04938

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Timonium	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Josephs Hospital		d. STREET ADDRESS 1911 York Rd. 21093	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Edward Middle Oscar Last WILHELM		4. DATE OF DEATH Month April Day 20 Year 1967	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 22, 1891
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months 13 Days 1 Hours 1 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Florist hepper-retire		10b. KIND OF BUSINESS OR INDUSTRY Florist	
11. BIRTHPLACE (County & State, or foreign country) Balto. Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Edward Wilhelm		14. MOTHER'S MAIDEN NAME Ida Susan Gill	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) none		16. SOCIAL SECURITY NO. 216-10-6170	
17. INFORMANT Family records		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Massive right intra-cerebral hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 19 o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 19 , 19 67 , to April 20 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 20 , 19 67 , and that death occurred at 12:08 M, from causes and on the date stated above.			
22a. SIGNATURE Lawrence F. Misanik, M.D.		22b. DATE SIGNED April 20, 1967	
22c. PHYSICIAN'S NAME (Type) Lawrence F. Misanik, M.D.		22d. ADDRESS 7620 York Rd., Towson, Md. 21204	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/24/67	
23c. NAME OF CEMETERY OR CREMATORY Oulaney Valley Memorial		23d. LOCATION (City or Town) (County) (State) Cockeysville, Md.	
24. FUNERAL DIRECTOR John Burns Sons 610-12 York Rd. Tow. 21204		25a. REC'D BY REGISTRAR APR 25 1967	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04933

CERTIFICATE OF DEATH

04939

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Catonsville		c. LENGTH OF STAY IN 1b 5 mthlldys		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 30.4			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) SPRING GROVE STATE HOSPITAL				d. STREET ADDRESS 1360 Carroll Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Albert Last Williams				4. DATE OF DEATH Month April Day 1 Year 19 67			
5. SEX male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 4, 1905		9. AGE (In years last birthday) 61 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address Records: Spring Grove State Hospital			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest. DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Constrictive Heart failure DUE TO (c) Arteriosclerotic Cardiovasc. Disease							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Alzheimer's Disease							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that he (this hospital) attended the deceased from Oct. 11 , 19 66 , to 4/1 , 19 67 , that (I) (we) last saw the deceased alive on 4/1 , 19 67 , and that death occurred at 1039M , from causes and on the date stated above.							
22a. SIGNATURE Narciso W. Carmona M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) NARCISO W. CARMONA				22d. ADDRESS SPRING GROVE STATE HOSPITAL Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4/5/67		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Charles A. Rice				ADDRESS 661 W. Barre St.		25a. REC'D BY REGISTRAR DATE APR 3 1967	
						25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04940

CERTIFICATE OF DEATH

04940

1. PLACE OF DEATH a. COUNTY BALTIMORE MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FORT HOWARD			c. LENGTH OF STAY IN 1b 16 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) VETERANS ADMINISTRATION HOSPITAL				d. STREET ADDRESS 3907 HILTON ROAD		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RUDOLPH - WILSON				4. DATE OF DEATH Month Day Year APRIL 20 1967			
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 23, 1922		9. AGE (In years, last birthday) 44 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION		11. BIRTHPLACE (County & State, or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME ARTHUR WILSON				14. MOTHER'S MAIDEN NAME RACHAEL WILSON			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW II		16. SOCIAL SECURITY NO. _____		17. INFORMANT Address CLIN. RECORDS, VA HOSPITAL, FT HOWARD, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) CIRRHOSIS OF LIVER DUE TO (c) UPPER GASTRO-INTESTINAL BLEEDING						INTERVAL BETWEEN ONSET AND DEATH 12 HRS. MONTHS 2 DAYS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) PROBABLE PNEUMONIA						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 4/4/67 , 19 _____ , to 4/20/67 , 19 _____ , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 4/20/67 , 19 _____ , and that death occurred at 11:15AM from causes and on the date stated above.							
22a. SIGNATURE Pushpendra Senan				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 4/20/67	
22c. PHYSICIAN'S NAME (Type) PUSHPENDRA SENAN, M.D.				22d. ADDRESS VAH FORT HOWARD, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 4-26-67	23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland			
24. FUNERAL DIRECTOR Morton & Dyett Funeral Home				25a. REC'D BY REGISTRAR APR 25 1967		25b. REGISTRAR'S SIGNATURE J Charles Jones	

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CERTIFICATE OF DEATH



Name of Deceased		Date of Birth		Date of Death	
John Doe		10/10/1920		10/10/1980	
Sex		Age		Cause of Death	
Male		60		Heart Disease	
Place of Birth		Place of Death		Occupation	
New York, N.Y.		New York, N.Y.		Teacher	
Marital Status		Signature of Physician		Signature of Registrar	
Married		[Signature]		[Signature]	
Date of Burial		Burial Place		Burial Date	
10/15/1980		St. John's Church		10/15/1980	
Burial Place		Burial Date		Burial Time	
St. John's Church		10/15/1980		10:00 AM	
Burial Time		Burial Date		Burial Place	
10:00 AM		10/15/1980		St. John's Church	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04941

04941

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Dennis		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Dennis	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1819 Main Street		d. STREET ADDRESS 1819 Main Street	
3. NAME OF DECEASED (Type or print) First BESSIE Middle G. Last WRIGHTSON		4. DATE OF DEATH Month April Day 27 Year 19 67	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-14-1877
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 03 Days 01	11. IF UNDER 24 HRS. Hours 00 Min. 00
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas E. Gill		14. MOTHER'S MAIDEN NAME Mary K. Ebaugh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Miss Edith Wrightson, 1819 Main St. 21227		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension, A.S. CVD 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) terminal anemia DUE TO (c) Cerebral thromboses		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from May, 1954 to April 27, 1967 , that (I) (we) last saw the deceased alive on April 27, 1967 , and that death occurred at 9:50 M, from causes and on the date stated above.			
22a. SIGNATURE Dr. John C. Healy		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. John C. Healy		22d. ADDRESS 1311 Francis Ave. Balto., Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 4-29-1967	
23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION (City or Town) (County) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Avenue 21229		25a. REC'D BY REGISTRAR MAY 1 1967	
25b. REGISTRAR'S SIGNATURE J. Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04942

CERTIFICATE OF DEATH

04942

1. PLACE OF DEATH a. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY B. ALTIMORE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN 1b DUNDALK ##### 21222	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) St. Joseph Hospital		d. STREET ADDRESS BELCLARE 6826 ##### Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Harry Middle I. Last Yeager		4. DATE OF DEATH Month April Day 14 Year 1967	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 94 4-16- 72
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Refined Weigher		10b. KIND OF BUSINESS OR INDUSTRY Beth. Steel	
11. BIRTHPLACE (County & State, or foreign country) Penn.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME WILLIAM C. YEAGER		14. MOTHER'S MAIDEN NAME CLARA RESH	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 213-07/3467	
17. INFORMANT MARGARET E. YEAGER		Address AS IN # 2 ABOVE.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diffuse hemorrhage, large intestine DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic heart disease; diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from April 14 , 19 67 , to April 14 , 19 67 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on April 14 , 19 67 , and that death occurred at 9:05 PM from causes and on the date stated above.			
22a. SIGNATURE Juana S. Cockburn M.D.		22b. DATE SIGNED April 15, 1967	
22c. PHYSICIAN'S NAME (Type) Juana S. Cockburn, M. D.		22d. ADDRESS 7620 York Road, Towson 4, Md.	
23a. BURIAL CREMATION, RURAL (County)	23b. DATE THEREOF 4/18/67	23c. NAME OF CEMETERY OR CREMATORY BALTIMORE NATIONAL	23d. LOCATION (City or Town) (County) (State) BALTIMORE, MD.
24. FUNERAL DIRECTOR WALTER BROOKS BRADLEY ADDRESS DUNDALK, MD		25a. REC'D BY REGISTRAR APR 18 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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CERTIFICATE OF DEATH

Reg. Dist. No.

04943

04943

1. PLACE OF DEATH a. COUNTY <u>Baltimore</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) p. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville, Md.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kingsville, Md.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Johns Hopkins Medical School R-1 Box 13 Bel Air Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EDNA</u> First <u>ZANZINGER</u> Middle <u>ZANZINGER</u> Last <u>ZANZINGER</u>				4. DATE OF DEATH <u>April</u> Month <u>4</u> Day <u>1967</u> Year			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 12, 1898</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>office clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Contractor</u>			
11. BIRTHPLACE (State or foreign country) <u>Providence, Rhode Island</u>				12. CITIZEN OF WHAT COUNTRY? <u>United States</u>			
13. FATHER'S NAME <u>John Slingsby Boyes</u>				14. MOTHER'S MAIDEN NAME <u>Edna Boyes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>188-26259</u>		17. INFORMANT <u>Robert B. Bailey</u> Address <u>353 Echo Valley Pl. Newtown Square, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>INTESTINAL OBSTRUCTION</u> 12 hrs. DUE TO <u>CARCINOMA COMMON BILE DUCT</u> 4 mos. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertrophic Arthritis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>1-14</u> , 19 <u>62</u> to <u>4-4</u> , 19 <u>67</u> , that I last saw the deceased alive on <u>4-3</u> , 19 <u>67</u> , and that death occurred at <u>230 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>FORK, MD.</u> DATE SIGNED <u>4/4/67</u> ACTUAL SIGNATURE <u>Clifford F. Hudson</u> M.D. PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> <u>FORK, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>REMOVAL</u>		22b. DATE THEREOF <u>4/5/67</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Johns Hopkins School of Med. 709 N. Wolfe St. Balto.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS			
24a. REC'D BY REGISTRAR				24b. REGISTRAR'S SIGNATURE			
DATE <u>APR 6</u> 19 <u>67</u>				<u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in, the funeral director, TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in. Pages 1 and 2 should be filed with page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04944

04944

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>BALTIMORE</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Daniels</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Randallstown 21133</u> <u>03-1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>3221 Offutt Road</u>			
3. NAME OF DECEASED (Type or print) First <u>CHARLES</u> Middle <u>WILLIAM</u> Last <u>ZINKHAM</u>				4. DATE OF DEATH Month <u>4</u> Day <u>1</u> Year <u>1967</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/5/1942</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Finisher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dry Wall Business</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward L. Zinkhan</u>				14. MOTHER'S MAIDEN NAME <u>Frances L. Schmidt</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-40-4380</u>		17. INFORMANT Address <u>Mr. James V. Oldaker-3221 Offutt Rd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TAMPORADE DUE TO</u> <u>823.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>LACERATION OF HEART</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>PASSENGER AUTO RAN INTO TREE</u>					
20c. TIME OF INJURY Month, Day, Year <u>214</u> <u>4/11</u> <u>1967</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input checked="" type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>STREET</u>		20f. (City or town) (County) (State) <u>DANIELS BALTO CO MD</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>R. S. Fisher</u>		EXAMINER'S NAME (Type) <u>RUSSELL S. FISHER, M.D.</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>4/4/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Garden of Faith</u>		23d. LOCATION (City or Town) (County) (State) <u>Trumps Mill Rd, Balt., Md.</u>		
24. FUNERAL DIRECTOR <u>Loring Byers-8728 Liberty Rd. Randallstown, Md.</u>		25a. REC'D BY REGISTRAR <u>APR 5 1967</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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